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In The Supreme Court of the United States

October Term, 1987

NORTHERN GROUP SERVICES, INC., et al.,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., et al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

I.

Does the Employee Retirement Income Security Act (ERISA) preempt a State law which mandates that uninsured ERISA Plans be deemed "insurers" primarily liable for the payment of health and accident benefits contrary to the express provisions of the ERISA Plans, thereby imposing on ERISA Plans substantial administrative burdens and costs which are inconsistent from state to state and which those ERISA Plans never agreed to assume?

II.

If ERISA pre-empts the State law as applied to uninsured ERISA Plans, does it also pre-empt the State law as applied to uninsured ERISA Plans whose Plan Sponsors purchase "stop-loss" insurance to cover the Sponsors' potential funding liability to the Plan where the "stop-loss" insurance does not provide coverage of, or make payments to, the ERISA Plan or its participants or beneficiaries?

TABLE OF AUTHORITIES

CASES PAGE

Alessi v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) 8

Bone v. *Association Management Services, Inc.*, 632 F.Supp. 493 (S.D. Miss. 1986) 19

Children's Hospital v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985) 7, 13

Employers Association of New Jersey v. *New Jersey*, 601 F.Supp. 232 (D.N.J.), *aff'd. mem.*, 774 F.2d 1151 (3d Cir. 1985) 13

Federal Kemper Ins. Co. v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986) 4

Fort Halifax Packing Co. v. *Coyne*, ____ U.S. ____, 96 L.Ed.2d 1, 107 S.Ct. 2211 (1987) 8, 9

Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp. v. *Muir*, 819 F.2d 408 (3d Cir. 1987) 7, 13

Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724 (1985) 5, 6, 12, 19

Moore v. *Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986) 19

Pilot Life Ins. Co. v. *Dedeaux*, ____ U.S. ____, 95 L.Ed. 2d 39, 107 S.Ct. 1549 (1987) 8, 11

Powell v. *Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) 13

Shaw v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983) .. 7 16

United Food & Commercial Workers v. *Pacyga*, 801 F.2d 1157 (9th Cir. 1986) 13, 19

STATUTES:

28 U.S.C. § 1254(1) 2

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et. seq.,*: Section 514, 29 U.S.C. § 1144 ..... 2,5,9, 10,12

McCarran-Ferguson Act, 15 U.S.C. § 1012 (1982) 6

Section 3107 of the Michigan No-Fault Insurance Act, M.C.L.A. § 3107 3

Section 3109a of the Michigan No-Fault Insurance Act, M.C.L.A. § 500.3109a 2, 3, 4, 6, 7

CONGRESSIONAL MATERIALS

ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor (Committee Print of excerpts of H.R. Rep. No. 1785, 94th Cong. 2d Sess.) 8,11,12,14

OTHER

Supreme Court Rule 17.1(a) 19

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

Petitioners pray that a writ of certiorari issue to review a judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered on November 13, 1987.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is reported at 833 F.2d 85, and is reprinted in the Appendix, p. 1b, *infra*.

The memorandum decision of the United States District Court for the Eastern District of Michigan (Taylor, D. J.) is reported at 644 F.Supp. 535, and is reprinted in the Appendix, p. 1a, *infra*.

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was entered on November 13, 1987. On November 25, 1987, plaintiffs timely petitioned the Sixth Circuit for rehearing or for rehearing en banc. On December 30, 1987, the Sixth Circuit denied the petition for rehearing. Appendix, p. 1c, *infra*. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

This case involves Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1144 (1982), and Section 3109a of the Michigan No-Fault Insurance Act, M.C.L.A. § 500.3109a. These provisions are reprinted in the Appendix, p. 1d, *infra*.

STATEMENT OF THE CASE

Petitioners (Plaintiffs-Appellees below) Masco Industries, Inc. Employees' Benefit Plans (the Masco Plans) and Highland Appliance Companies Medical Benefit Plan (the Highland Plan) provide medical and other benefits to employees. (The Masco Plans and the Highland Plan are referred to collectively as the "Petitioner ERISA Plans.") The employer/sponsors of these plans self-fund the benefits; they do not purchase insurance policies to pay plan benefits. Each plan is an "employee benefit plan" formed pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq.*

Petitioner (Plaintiff-Appellee below) Northern Group Services (NGS) provides claims processing and other services for

the Petitioner ERISA Plans. NGS does not pay benefits out of its own assets, nor does it act as an insurer.

Automobile insurance companies in Michigan are required to offer no-fault automobile insurance coverage and to pay medical claims arising out of an automobile accident pursuant to M.C.L.A. § 500.3107.

If a participant in one of the Petitioner ERISA Plans is injured in an automobile accident and receives medical treatment for injuries suffered in that accident, the participant has two potential sources from which the medical expenses can be paid: (1) the automobile insurer and (2) the Petitioner ERISA Plan.

Many claims could be payable by the auto insurer but not by the medical plan. For example, the auto insurer is required to pay for certain rehabilitation costs, which are not covered by the Petitioner ERISA Plans. Similarly, the Petitioner ERISA Plans have a dollar limit on lifetime Major Medical claims. For example, they will not pay more than $100,000 in Major Medical claims over the lifetime of the covered individual. Auto insurers are required to pay all medical claims arising out of the automobile accident, without any limitation as to amount.

Precisely because the participants other sources of payment for various health and welfare benefits, each Petitioner ERISA Plan contains a "coordination of benefits" provision which expressly states when and how the Petitioner ERISA Plan will be liable if there are multiple potential benefits. The Masco Industries, Inc. Employees' Benefit Plan for Salaried Employees, for example, expressly makes the no-fault auto insurance the "primary" coverage and limits the Plan's liability to costs *not* covered by no-fault auto insurance.

The respondent automobile insurers also offer policies containing "coordination of benefits" provisions. Automobile insurers in Michigan are required to offer this "coordination of

benefits" option by M.C.L.A. § 500.3109a, which states in pertinent part:

> An insurer providing personal protection [automobile] insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident *coverage* on the insured. [Emphasis added.]

As its use of the word "coverage" emphasizes, M.C.L.A. § 500.3109a envisions and mandates that auto insurance benefits be coordinated only with other insurance benefits. Nonetheless, the respondents sought reimbursement from the Petitioner ERISA Plans for medical payments. In some cases respondents have sought reimbursement from NGS even though NGS merely processes claims for the Petitioner ERISA Plans and is not an insurer.

The respondents based their claims for reimbursement from the Petitioner ERISA Plans on cases interpreting M.C.L.A. § 500.3109a in the context of disputes between automobile and health insurers. In *Federal Kemper Ins. Co.* v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W. 2d 590 (1986), the Michigan Supreme Court held, as a matter of law, that where there is both health insurance and no-fault automobile insurance, the health insurer is primarily liable for coverage of a claimant's medical expenses resulting from an automobile accident and the no-fault auto insurer is only secondarily liable. The insurers contended that Section 3109a means that no-fault automobile insurance must be secondary not only to health insurance but also to any other benefit source, including benefits under a self-funded ERISA plan. In other words, the auto insurers claimed that, for purposes of Section 3109a, the Petitioner ERISA Plans and other self-funded ERISA plans should be deemed to be health insurers.

To resolve this dispute, petitioners commenced an action in the United States District Court for the Eastern District of

Michigan seeking a declaration that the insurers' attempts to use Section 3109a to make claims against the Petitioner ERISA Plans was unconstitutional. Petitioners alleged that, as applied to a self-funded ERISA Plan, Section 3109a would "relate to" an ERISA employee benefit plan and, therefore, would be pre-empted by ERISA Section 514(a), 29 U.S.C. § 1144(a), and that Section 3109a could not be saved from pre-emption as a state insurance law because, under ERISA Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), the Petitioner ERISA Plans could not be deemed to be insurers.

Petitioners filed a motion for summary judgment or, in the alternative, a preliminary injunction, contending that there were no genuine issues of material fact with respect to their pre-emption claims. Certain respondents filed cross-motions for summary judgment contending, among other things, that the Highland Plan could not claim pre-emption because it was an "insured plan" within the meaning of ERISA, as construed by *Metropolitan Life Ins. Co.* v. *Massachusetts,* 471 U.S. 724 (1985).

The District Court granted petitioners' motion for summary judgment and denied respondents' motions for summary judgment. In its Memorandum Opinion and Order, the District Court held that ERISA did pre-empt Section 3109a as applied to ERISA employee benefit plans because the statute "relate[d] to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). The District Court reasoned that, if Section 3109a was not pre-empted, "the State of Michigan would otherwise by its insurance laws be regulating federal ERISA plans and dictating when and to whom benefits should be paid . . ." and it concluded that "[c]ertainly this court cannot permit the State Legislature to intrude into an area which Congress specifically chose to leave open for private discretion." 644 F.Supp. at 538. The District Court also found that Section 3109a was not protected by the insurance savings clause in ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A),

because the Petitioner ERISA Plans could not be "deemed" an insurer by virtue of the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B).

The Sixth Circuit reversed. It agreed that Section 3109a clearly "relate[d] to" the Petitioner ERISA Plans and, in fact, "conflicts directly" with these plans because "it allocates obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan." 833 F.2d at 89. Nonetheless, the Sixth Circuit concluded that Section 3109a was saved from preemption by the insurance savings clause because Section 3109a "clearly 'regulates insurance' within the meaning of the savings clause" and "falls within the meaning of 'business of insurance' covered by the McCarran-Ferguson Act." 833 F.2d at 90. The Sixth Circuit also concluded that application of Section 3109a to ERISA plans was not barred by the "deemer clause." The Sixth Circuit recognized that *Metropolitan Life Insurance Co.* v. *Massachusetts,* 471 U.S. 724 (1985), had created "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." It found that the Highland Plan could not be saved by the "deemer clause" because the employer purchased stop-loss insurance; and, therefore, it was, in effect, an insured plan. 833 F.2d at 91. Although the Masco Plan was totally self-insured, the Sixth Circuit concluded that the deemer clause did not bar state regulation of the Masco Plan. Since ERISA preserved "the principle favoring state regulation of insurance," it would be "contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, 'the presumption is against pre-emption' . . . ." 833 F.2d at 92. The Sixth Circuit concluded that this "presumption" was not rebutted in this case because the state had a "strong, legitimate interest in keeping down the costs of [hospitilization] coverage and thus was justified in spreading the loss,

where there is multiple coverage, to entities other than no-fault insurers." 833 F.2d at 93. While it recognized that this would impose substantial administrative and financial burdens on ERISA plans, the Sixth Circuit concluded that such burdens would least disrupt "the state's ability to administer a uniform scheme of 'other-insurers' or 'coordination of benefits' law." 833 F.2d at 93. Since it could find no federal interest in uniformity in administration of ERISA plans which outweighed this "injury to the State scheme . . .," the Sixth Circuit refused to find that ERISA pre-empted Section 3109a. 833 F.2d at 93.

REASONS FOR GRANTING THE WRIT

I.

REVIEW IS NECESSARY TO RESTORE CONGRESS' PURPOSE TO ESTABLISH EMPLOYEE BENEFIT PLAN REGULATION AS AN EXCLUSIVELY FEDERAL CONCERN, TO ELIMINATE CONFLICTING STATE REGULATION OF EMPLOYEE BENEFIT PLANS AND TO RESOLVE A CONFLICT WITH DECISIONS OF OTHER CIRCUITS

The Sixth Circuit's decision is inconsistent with this Court's leading decisions on ERISA pre-emption; indeed, it destroys Congress' purpose to establish employee benefit plan regulation "as exclusively a federal concern." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98–99 (1983). The decision below is also inconsistent with decisions of other circuits. *See, e.g., Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408 (3d Cir. 1987); *Children's Hospital* v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985).

Last Term this Court succinctly but forcefully restated that ERISA's pre-emption provision was intended to "eliminat[e]

the threat of conflicting and inconsistent state and local regulation" of employee benefit plans. *Fort Halifax Packing Co.* v. *Coyne*, ____ U.S. ____, 96 L.Ed.2d 1, 10, 107 S.Ct. 2211 (1987), quoting Representative Dent. Similarly, in *Pilot Life Ins. Co.* v. *Dedeaux*, ____ U.S. ____, 95 L.Ed.2d 39, 46, 107 S.Ct. 1549 (1987), this court explained:

> . . . [T]he express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish pension plan regulation as exclusively a federal concern. "* * * The House and Senate Sponsors emphasized both the breadth and importance of the pre-emption provisions. Representative Dent described the "reservation to Federal authority the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement." [Citations omitted.]

See also ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, Committee on Education and Labor (Committee Print of Excerpts from H.R. Rep. No. 94-1785) ("Erisa Oversight Report"), p. 8 ("In electing deliberately to preclude state authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities.")

Thus, as *Fort Halifax* noted, this Court has "not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements." 96 L.Ed.2d at 10. *See also Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) ("This [pre-emption] provision demonstrates that Congress intended to depart from its previous legislation that 'envisioned the exercise of state regulation power over pension funds,' and meant to establish pension plan regulation as exclusively a federal concern.")

Notwithstanding the clear mandate in the statutory language, the legislative history and this Court's decisions,

the Sixth Circuit decision destroys any possiblity of uniformity and not only permits, but mandates, that ERISA plans be subjected to conflicting state regulations.

The Sixth Circuit acknowledged that Michigan's Section 3109a not only relates to the Petitioner ERISA Plans, but, in fact, "conflicts directly" with them by "allocat[ing] obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan." 833 F.2d at 89. Indeed, as the Sixth Circuit recognized, Section 3109a mandates that an ERISA plan is primarily liable for health care costs even if the ERISA plan contractually agreed to pay health benefits only if the participant had no other source of insurance.

The Sixth Circuit nonetheless decided that, as applied to uninsured ERISA plans generally and the Petitioner ERISA Plans in particular, the State law cannot be pre-empted because subjecting ERISA Plans to state insurance regulation was more important than any arguable federal interest in uniform plan administration. In other words, faced with a direct conflict between an ERISA plan and a state law, the Sixth Circuit determined that the state law, not the provisions of the ERISA plan, should govern. In so deciding, the Sixth Circuit necessarily "dictate[d] what benefits should be paid under a plan," and thus it directly repudiated this Courts' numerous decisions that any state law mandating benefits should be pre-empted. *See Fort Halifax, supra,* 96 L.Ed.2d at n. 8 (describing a state mandated benefit law as "precisely the type of conflict that ERISA's pre-emption provision was intended to prevent").

Worse, because different states' insurance laws resolve insurance "coordination of benefit" provisions in a variety of ways, the Sixth Circuit necessarily requires employers to administer their plans differently in each state in which they have employees — a result which directly conflicts with the pre-emption provision's purpose to "ensure[] that the administrative practices of a benefit plan will be governed by only a

single set of regulations." *Fort Halifax, supra,* 96 L.Ed.2d at 11.

While the Sixth Circuit paid lip service to Congress' desire to ensure "a uniform scheme for coordinating complex administrative schemes, unaffected by divergent regulatory schemes in different states," 833 F.2d at 88, it then directly flouted the legislative intent by insisting that Congress' desire to ensure a uniform scheme for ERISA plan regulation was subordinate to Congress' desire to "preserve state regulation of insurance" and it held that state insurance laws could also bind self-insured ERISA plans notwithstanding the "deemer" clause in 29 U.S.C. § 1144(b)(2)(B), which expressly states that an employee benefit plan cannot be deemed to be "an insurance company or other insurer . . . or to be engaged in the business of insurance. . . ."

Having concluded that ERISA plans could be deemed "insurers" for purposes of state laws regulating insurance, and recognizing that its decision created the possibility of inconsistent state regulation, the Sixth Circuit then asked:

> . . . [S]hould interstate uniformity in the coordination of a plan's benefits with other insurance benefits override a state's traditional interest in a uniform rule for allocating comparative liability among all insurers [i.e. including ERISA plans which are deemed to be "insurers"]? [833 F.2d at 93]

The Sixth Circuit's answer to this question is shocking: It conceded that the courts could simply "defer willy nilly to the provisions of the ERISA plan," but it concluded that this would be "an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial review." 833 F.2d at 94.

The answer is shocking because it ignores Congress' clear mandate to allow ERISA plans to define the benefits and

obligations they are prepared to assume and because it glibly ignores the fact — emphasized by this court last Term in *Pilot Life, supra,* 95 L.Ed.2d at 50–51 — that ERISA Section 502(a) creates a comprehensive "civil enforcement scheme" to ensure that ERISA plan fiduciaries do not act arbitrarily.

It is even more shocking because its deference to state regulation rejects the fundamental premise of ERISA pre-emption: national uniformity. As the ERISA Oversight Report, p. 9, stated: " . . . [I]t is our finding that the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded."

Having concluded that state interests, not federal interests, should control conflicts between ERISA plans and state laws purporting to regulate ERISA plans, the Sixth Circuit then reiterated its holding that even self-insured ERISA plans are subject to state regulation unless they can demonstrate an "ERISA interest in uniformity" which outweighs a state's interest in regulating ERISA plans as if they were insurers. 833 F.2d at 94. But since the Sixth Circuit had rejected uniform administration itself as a sufficient ERISA interest, the Sixth Circuit virtually destroyed the effect of ERISA pre-emption and permits virtually complete state regulation of all ERISA plans including self-funded plans.

Thus, unless reversed, the Sixth Circuit's ruling will destroy the very purpose of ERISA pre-emption and make it impossible to administer any nationwide ERISA plan uniformly.

II.

REVIEW IS NECESSARY TO PREVENT THE SIXTH CIRCUIT'S DECISION FROM VOIDING THE EXPRESS PROVISIONS OF ERISA'S "DEEMER" CLAUSE

The Sixth Circuit justified its destruction of uniform plan administration by arguing that Congress' desire to preserve state regulation of insurance, as stated in the "insurance savings clause" of 29 U.S.C. § 1144(b)(2)(A), justified some state regulation of uninsured ERISA Plans. 833 F.2d at 92. In doing so, the Sixth Circuit effectively voided the express provisions of the "deemer" clause in 29 U.S.C. § 1144(b)(2)(B).

In *Metropolitan Life Ins. Co.* v. *Massachusetts,* 471 U.S. 724, 746–747 (1985), this Court recognized that Congress enacted the "deemer" clause to "modif[y] the insurance saving clause and thus created a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." In effect, as the 1977 Activity Report of the House Committee on Education and Labor explained,

> . . . the "deemed" language was utilized to create an irrebutable presumption that these plans are not insurance, trust companies, etc. for purposes of state regulation. . . . *The irrebutable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance, trust or securities activities generally regulated by any state.* [Emphasis added.]

The "deemer" clause reflects Congress' recognition that ERISA plans would engage in numerous activities which could be arguably characterized as "insurance" or the "business of insurance" within the meaning of McCarran-Ferguson Act and, therefore, that only an express statutory mandate that these activities not cause ERISA plans to be

treated as "insurers" would ensure that the threat of conflicting state regulation would be eliminated.

This distinction between "insured" and "uninsured" or "self-insured" plans has been accepted by every Circuit to consider the issue. *See, e.g., Children's Hospital* v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Powell* v. *Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, ____ U.S. ____ (1986); *United Food & Commercial Workers* v. *Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408 (3d Cir. 1987). Only the Sixth Circuit's decision reaches a contrary result; and it does so for reasons that turn the "deemer" clause on its head by concluding that ERISA plans could be "deemed" insurers for purposes of state insurance laws whenever "preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally. . . ." 833 F.2d at 95.

The Sixth Circuit, in effect, acknowledged that it was creating an unprecedented construction of the "deemer" clause which conflicted with decisions of this Court and virtually every other court to construe the "deemer" clause when it could cite only one decision to support its result — *Employers Association of New Jersey* v. *New Jersey*, 601 F.Supp. 232 (D.N.J.), *aff'd. mem.*, 774 F.2d 1151 (3d Cir. 1985). But that citation itself demonstrates the extent to which the Sixth Circuit has departed from the standards established by this and other courts. *Employers Association, supra,* confronted virtually the identical question which the court addressed in *Metropolitan Life;* and it held that a New Jersey statute which regulated the content of insurance policies (not ERISA plans) was not preempted by ERISA. The District Court expressly distinguished cases where state laws had been preempted because they "either directly or indirectly, purported to

regulate employee benefit plans and not solely to regulate insurance as in the instant case." 601 F.Supp. at 240.

In relying on such a slender reed, the Sixth Circuit demonstrated a disregard for the statutory language and the legislative history. Instead, it was engaged in an artful effort to create a role for state legislation directly contrary to Congress' intention. Indeed, the ERISA Oversight Report, pp. 9-10, commented on just such artful efforts:

> It has come to our attention that our efforts to ensure minimum disruption of the regulatory efforts of the states in the fields of insurance, banking and securities, generally are being construed as a reservation of state authority over employee benefit plans themselves. The argument is predicated on an interpretation of the language ". . . shall be deemed . . ." as used in section 514(b)(2)(B) to limit the scope of the prohibition contained therein to the use by State authority of a legal fiction to declare a plan to be insurance, or a trust company, etc., where it is not. As this line of reasoning goes, those plans which actually contain the characteristics of insurance, etc., would then remain subject to state regulation.
>
> Such interpretation, while artful, is not supported by a fair reading of the statute and legislative history.

III.

THE SIXTH CIRCUIT'S DECISION DESTROYS ANY POSSIBILITY OF ADMINISTERING ERISA PLANS BY REFERENCE TO PLAN DOCUMENTS AND MANDATES CASE-BY-CASE LITIGATION TO DETERMINE PLAN LIABILITY, THUS EFFECTIVELY DELEGATING RESPONSIBILITY FOR PLAN ADMINISTRATION TO THE COURTS

The Sixth Circuit's decision not only destroys uniformity; it makes it practically impossible for plan administrators to rely on the plan documents to administer ERISA plans. Instead, because it creates a balancing test which can only be applied on a case-by-case basis, the Sixth Circuit's decision virtually ensures constant litigation over the nature and extent of plan liability, thus effectively requiring courts, not plan administrators, to decide benefit claims.

This case provides a perfect example of the administrative dilemma created by the Sixth Circuit decision.

Both the Masco Plans and the Highland Plan have participants in numerous states. Indeed, virtually every sizeable ERISA plan has participants in many states because large employers do business across state lines. As the Sixth Circuit acknowledged, virtually every state has a statute or common law rule defining an insurer's obligations to coordinate benefits with other insurers. *See* 833 F.2d at 93. If, as the Sixth Circuit holds, an ERISA plan is simply another "insurer" within the meaning of those state laws, the plan administrator must evaluate each claim in the context of every state law which arguably impacts the claim for benefits.

Assume, for example, that a Masco employee in California is injured in an automobile accident in California. How does the plan administrator decide whether the Masco Plan bears

any liability for medical care? By pre-empting all state laws, Congress intended the question of benefits to be answered solely by reference to the plan documents. The Sixth Circuit, however, requires the plan administrator to examine the plan documents and California law and then to determine whether the interests served by California law outweigh the plan's interests. Since the plan administrator has fiduciary responsibilities to act fairly and can be found personally liable under ERISA § 502 if he decides incorrectly, one can reasonably expect him to avoid any decision of consequence by resorting to the courts for a declaration of rights. But even if he decides on his own, the plan administrator can expect to be challenged either by an auto insurer (as happened in this case) or by a plan participant. And the problem only gets worse. Consider, for example, the same Masco Plan administrator who now faces a claim by a Michigan resident involved in an automobile accident in California. The plan administrator now must not only weigh the competing interests of state law and ERISA Plan, he must also determine which state's interests should be weighed — in other words, he must become a choice of law expert as well.

Consider, finally, a plan administrator located in the Third, Fourth, Fifth or Ninth Circuit facing a claim by a Michigan resident involved in an accident, whether in Michigan or in California. Which Circuit's law should the administrator attempt to apply?

Examples could be multiplied. The three given, however, demonstrate why the Sixth Circuit's decision should be reversed and why this Court has repeatedly emphasized that ERISA pre-emption was enacted so that plan administrators — not state governments — could decide the nature and extent of benefits available to ERISA plan participants. *See Fort Halifax, supra,* 96, L.Ed.2d at 10.

To this point, we have only discussed the effect of the Sixth Circuit's decision on plan administration. It has an even more

deleterious effect on the financial integrity of the ERISA plans. The Sixth Circuit decision requires every ERISA plan having participants or beneficiaries in Michigan to assume new financial obligations for health benefits which were not contemplated when the plans were created and, indeed, which the plans themselves expressly refused to assume. Like the Masco Plan, many employers elect to provide health benefits only if the participant has no other source of health insurance benefits, such as those paid by automobile insurers. The Sixth Circuit decision makes those employers primarily liable for all health care costs of participants injured in automobile accidents — at least until the plan's assets or, perhaps, the sponsoring employer's assets, are exhausted. By transforming these ERISA plans from a secondary to a primary source of health care benefits, the Sixth Circuit has imposed a gigantic cost on ERISA plans which many may not be willing or able to afford. As a result, employers may be forced to reduce or eliminate health care benefits because, under the Sixth Circuit's decision, by agreeing to assume any liability for health care costs arising from an auto accident, ERISA plans are required to assume all liability. As an alternative, to pay the substantial additional cost of health care benefits, the employer may choose to eliminate other benefits that are already covered by the plans — benefits which may well be more desirable to the employees than the benefits mandated by Section 3109a.

In short, the Sixth Circuit's decision presents an employer with the very dilemma which Congress intended to eliminate when it enacted ERISA's broad pre-emption provision. A widely-cited law review article, cited with approval in *Shaw, supra,* 103 S.Ct. at 2901 n. 19, has described this dilemma very well:

> If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice

for employer or labor and management negotiators: either abandon the funding of benefit plans through insurance policies or be willing to accept all encompassing uniform national contracts. For if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's pre-emption provisions, which were formulated to relieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation. Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employment Retirement Income Security Act of 1974,* 46 U. Chi. L. Rev. 23, 68–69 (1978).

Actually, the situation created by the Sixth Circuit's decision is much worse. The law review author assumes that uniformity could be achieved by "incorporating into the plan all of the benefits each state requires." *See also Fort Halifax, supra,* 96 L.Ed.2d at 10, discussing *Alessi, supra,* and *Shaw, supra.* But that simply is not possible in this case because state requirements themselves are inconsistent; and, therefore, no plan could avoid the administrative and financial burdens created by the Sixth Circuit's decision by simply adopting all state law requirements.

In summary, the Sixth Circuit decision has truly immense consequences for ERISA plans. If it is not reversed, those plans can no longer define their own benefits and administrative procedures; they become creatures of every state insurance law which, in the view of a court balancing the plan against state interests, is considered to be more important than the ERISA plan. That is precisely what Congress intended to prevent when it enacted ERISA Section 514.

IV.

REVIEW IS ALSO NECESSARY TO RESOLVE A CONFLICT WITH DECISIONS OF THE NINTH CIRCUIT AS TO WHETHER A PLAN SPONSOR'S PURCHASE OF STOP-LOSS INSURANCE CAUSES THE PLAN TO BECOME AN INSURED PLAN WITHIN THE MEANING OF *MASSACHUSETTS* V. *METROPOLITAN LIFE INS. CO.*

This court's decision in *Metropolitan Life* described a distinction between self-insured (or uninsured) and insured ERISA Plans. The Masco Plan is a self-insured plan. The Highland Plan is also self-insured; but the employer and plan sponsor purchased stop-loss insurance to provide protection for its funding obligations to the Highland Plan. The Highland Plan did not purchase the insurance; the Highland Plan remains solely responsible for the payment of plan benefits to participants; the employer's contributions to the plan are the sole assets of the Highland Plan; no participant or beneficiary has rights to receive payments from the insurer; and no insurance contract or policy would ever be involved in any claim by a participant or beneficiary against the Highland Plan. Petitioners thus argued that the Highland Plan should be deemed a self-insured plan within the meaning of *Metropolitan Life*. The District Court agreed. 644 F.Supp. at 538. But the Sixth Circuit disagreed and concluded that the Highland Plan was insured.

By its ruling, the Sixth Circuit created a conflict among the circuits which should be resolved by this court. *See* Supreme Court Rule 17.1(a). The Ninth Circuit has held that an employer's purchase of stop-loss insurance cannot make the plan an "insured plan" within the meaning of *Metropolitan Life*. *Moore* v. *Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986); *United Food & Commercial Workers* v. *Pacyga*,

801 F.2d 1157, 1161 (9th Cir. 1986); *see also Bone* v. *Association Management Services, Inc.*, 632 F.Supp. 493, 495 (S.D. Miss. 1986).

United Food & Commercial Workers perhaps best illustrates this conflict because it is directly contrary to the Sixth Circuit's decision on very similar facts. The Ninth Circuit held that an Arizona antisubrogation insurance law was preempted when applied to an ERISA Plan even though the ERISA Plan had purchased stop-loss coverage:

> The type of stop-loss insurance carried by the Plan herein cannot be termed health insurance, nor can it be said that the Plan is providing an insurance contract to its participants. The stop-loss coverage provides for payment to the Plan of up to $1.5 million to reimburse the Plan in the event that it must pay out more than a certain amount in claims in a given year. The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should properly be termed a non-insured plan, protected by the deemer clause and preemptive of the Arizona antisubrogation law. 801 F.2d at 1161-1162.

Thus, this court should also grant the petition so that it can resolve this conflict and clarify the distinction between "insured" and "self-insured" ERISA plans which it made in *Metropolitan Life.*

CONCLUSION

For all these reasons, this Court should grant the petition so that it can establish the correct relationship between ERISA and state mandated benefit laws, reconcile the conflict in the lower courts, and forestall future adverse effects of such state statutes on employee benefit plans.

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DATED: March 25, 1988

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

NORTHERN GROUP SERVICES, INC., et al.,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., et al.,
Respondents.

APPENDIX

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APPENDIX
TABLE OF CONTENTS

		PAGE
Appendix A:	Memorandum Opinion and Order of the District Court, June 11, 1986	1a
Appendix B:	Opinion of the Court of Appeals, November 13, 1987.....	1b
Appendix C:	Order of the Court of Appeals, denying Petition for Rehearing en banc, December 30, 1987.....	1c
Appendix D:	Relevant Statutory Provisions ..	1d
I.	EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 29 U.S.C. Section 524 § 1144	1d
	(a) Supersedure; effective date	1d
	(b) Construction and application	1d
	(c) Definitions	2d
	(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited	2d
II.	MICHIGAN NO-FAULT INSURANCE ACT M.C.L.A. § 500.3109a	2d

APPENDIX A

Memorandum Opinion and Order
June 11, 1986

(Filed June 11, 1986)
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION
644 F.Supp.535

NORTHERN GROUP SERVICES, INC., et al.
Plaintiffs

v.

AUTO OWNERS INSURANCE COMPANY, et al.
Defendants.

Civ. No.
85-75383

MEMORANDUM OPINION AND ORDER

ANNA DIGGS TAYLOR, District Judge.

[536] This is an action for declaratory and injunctive relief. Plaintiff Northern Group Services, Inc. (NGS) is the Plan Supervisor for the plaintiff employee benefit plans; which include the Masco Industries, Inc. Employee Benefit Plan for Hourly Employees of Farming Technology; the Masco Industries, Inc. Employees' Benefit Plan for Salaried Employees; the Masco Industries, Inc. Self-funded Benefit Plans (the Masco Plans) and the Highland Appliance Companies Medical Benefit Plan (Highland Plan). These employee health and welfare benefit plans are subject to regulations contained in the Employee Retirement Income Security Act, 29 U.S.C. § 1132(e). This court also has jurisdiction pursuant to 28 U.S.C. §§ 1331, 2201-2202.

[537] The Plans provide health and medical benefits to the Plan participants and their beneficiaries. Their benefits include payment of medical, surgical, hospital, nursing and rehabilitative costs which result from injuries the participant

or beneficiary may suffer from an automobile accident. Each Plan contains a coordination of benefits provision which states that the Plan will be secondarily liable, after statutorily required no fault vehicle insurance coverage, for payment of benefits to such injured beneficiaries. The typical clause is found in the Masco Plan:

> If your state has a no-fault motor vehicle law, the coverage required by the state is considered primary for motor vehicle related medical expenses . . . Any eligible expenses which are not paid by that carrier will then be considered for payment by Masco Medical Plan. The Masco Medical Plan is considered secondary for no-fault motor vehicle expenses.

The defendants are seven insurance companies which provide medical insurance coverage for injuries related to automobile accidents: State Farm Mutual Automobile Insurance Company, Auto Owners Insurance Company, Auto Club Insurance Association, Farmers Insurance Exchange, Citizens Insurance Company of America, Michigan Mutual Insurance Company, and Allstate Insurance Company. These insurance companies do business in the State of Michigan. They have issued no-fault automobile insurance policies to Michigan residents pursuant to the provision of the Michigan No-Fault Automobile Insurance Act, M.C.L.A. § 500.3109a, which states that, when an insured is protected by other health and accident insurance coverage, a coordination of benefits policy must be offered to that insured: "[a]n insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates deductibles and exclusions reasonably related to other health and accident coverage on the insured."

Plaintiffs seek the adjudication of this court that M.C.L.A. § 500.3109a is preempted by ERISA; or alternatively, they

seek an order restraining defendants from claiming reimbursement from plaintiffs for the medical expenses which defendants have paid to beneficiaries of plaintiff ERISA plans pursuant to no-fault insurance policies. The parties have filed cross motions for summary judgment.

As a preliminary matter, defendant State Farm argues that plaintiffs lack standing to bring this claim. 29 U.S.C. § 1132(a)(3) provides that plan participants, beneficiaries and fiduciaries may bring an ERISA claim.

State Farm contends that plaintiff NGS, as Plan Administrator, lacks the discretionary control over the assets of these plans which is characteristic of true fiduciaries. ERISA defines a fiduciary as one who "exercises any discretionary authority or discretionary control respecting management of such plans or . . . disposition of its assets, he renders investment advice for a fee or other compensation . . . with respect to any moneys or other property, or he has discretionary authority or responsibility in the administration of the plan." 29 U.S.C. § 1002(2). Although William Alcott, III, the President of NGS, testified at his deposition that Masco Inc. retains substantial decisionmaking power over its plans, NGS as supervisor of the Plans, provides administrative services, such as the determination of claims, on the Plan's behalf. Moreover, under 29 U.S.C. § 1132(d)(1) this circuit has held that Plans may sue and be sued as an entity. *Saramar Aluminum Co. v. Pension Plan for Employees of the Aluminum Industry,* 782 F.2d 577, 581 (6th Cir. 1986). "The Plan, as the party before the court, necessarily includes those who must act for the Plan [such as NGS] to administer it and to effectuate its policies." *Id.* This court accordingly finds that plaintiffs do have standing to bring this action. Moreover, defendants themselves have sued NGS as administrator, so NGS does have a substantial stake in the outcome of this case.

NGS and the Plans argue here that M.C.L.A. § 500.3109a is a state law which "relates to" an employee benefit plan with [538] in the meaning of 29 U.S.C. § 1144(a) which provides that "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." The term "relates to" has been interpreted by the United States Supreme Court to refer to any state law which has "a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983).

The No-Fault Act will accordingly be preempted unless, as defendants allege, it falls within the savings clause of ERISA. Section 1144(b)(2)(A) of ERISA provides that nothing in section 1144(a) shall be construed to exempt a state law which regulates insurance, banking or securities. However, section 1144(b)(2)(B) states that ERISA plans "shall not be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for the purpose of any law of any state purporting to regulate insurance companies." The Masco and Highland Plans do not provide insurance coverage for participants and they are not insurers within the meaning of ERISA or any other definition of that term, they merely pay benefits from a fund. There was argument here that plaintiff Highland Plan was an insured plan, as it has purchased some insurance. The United States Supreme Court has indeed defined an insured plan as one which purchases insurance for its participants. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 2385, 85 L.Ed.2d 728 (1985). The evidence clearly shows, however, that the insurance acquired by the Highland Plan is obtained to insure the Plan against the employer's failure or inability to make contributions to the Trust Fund.

The Michigan No-Fault Automobile Insurance Act is preempted to the extent that it has impact on the ERISA Plans. The applicable ERISA statute provides that all state laws which relate to employee benefit plans are superseded by ERISA. 29 U.S.C. § 1144(a). Therefore, plaintiffs claim, section 500.3109a is preempted by ERISA because the State of Michigan would otherwise by its insurance laws be regulating federal ERISA plans and dictating when and to whom benefits should be paid by federally authorized fiduciaries. It appears to the court that the conclusion of preemption is mandatory in this instance because to allow the State of Michigan to control payment of federal benefits would be contrary to Congress' intent to "occupy [that] field." *Ogden v. Michigan Bell Tele. Co.*, 571 F.Supp. 520, 523 (E.D. Mich.1983). Congress has determined that private fiduciaries are to administer such plans in their discretion, in accordance with certain federal policies. To permit the state also to regulate distribution of the assets of those same plans would inevitably result in thwarting Congressional policy and would also discourage employers from establishment of new plans. Congress did not see fit to dictate payment of any specific benefits after full consideration of that alternative. It chose to free the fiduciary from arbitrary constraints. The Supreme Court directed questions concerning the wisdom of that intent directly to Congress. *Metropolitan Life*, 105 S.Ct. at 2385. Certainly this court cannot permit the State Legislation to intrude into an area which Congress specifically chose to leave open for private discretion.

Case law requires this conclusion. In *Children's Hospital v. Whitcomb*, 778 F.2d 239,242 (5th Cir. 1985), another declaratory judgment action, the hospital sued for a determination regarding the meaning and application of provisions of its self-insured Employee Welfare Benefit Plan under

ERISA. A member of the hospital's Plan was treated in Louisiana for mental and emotional disorders. The Plan limited payment for such treatment to $50,000 and she demanded full payment. The hospital administrator denied the request.

The Louisiana statute provided that the plans must pay benefits for mental or nervous disorders under the same conditions as they pay benefits for other treatment. The Court of Appeals for the Fifth Circuit af[539]firmed the district court's decision that ERISA mandates that private ERISA plan provisions must control and supersede conflicting state law. The court made its ruling based upon an analysis of ERISA's preemption, insurance savings and deemer clauses. It held that "ERISA preempts the Louisiana statute insofar as it relates to a self-insured plan, although it would not preempt if the plan were an insured plan." *Id.* at 242. This distinction was also made by the *Metropolitan Life* Court. 105 S.Ct. at 2393.

The factual situation of *Auto Club Ins. Asso. v. Pipeline Industry Benefit Fund,* ____ F.Supp. ____ CA No. 85-70415 (E.D.Mich. 12/13/85) (Cook, J.), is remarkably similar to this case. In *Auto Club Ins.*, the plaintiff insurer had paid medical expenses of its insured and sued the Plan for reimbursement under the coordinated benefit statute — M.C.L.A. § 500.3109a. Two of the issues before that court were whether M.C.L.A. § 500.3109a relates to the Plan and whether section 500.3109a is exempt from ERISA preemption principles.

The court held that section 500.3109a would, if given effect, directly regulate the uninsured Pipeline Benefit Fund and was accordingly preempted. The savings clause will only save state laws regulating commercially insured plans from preemption.

Defendants also argue that Michigan law controls here because the parties are estopped from denying their contractual agreement that "to the extent not inconsistent with

Federal law the Plan shall be interpreted under the laws of Michigan." But defendants fail to recognize that section 500.3109a does indeed conflict with ERISA, a federal statute. The Masco Plan in this case expressly provides that payment of benefits will be secondary to coverage which may be required by the state. The other plans incorporate similar language.

The No-Fault Act, according to defendant, raises Plan status to that of primary liability. It would be highly inconsistent with federal law to permit such a reading to govern. The principles of estoppel are also inapplicable under these circumstances.

Defendants also allege that two of the Plan's members must have misrepresented that they had other insurance coverage to the insurance agent because otherwise, a coordination of benefits policy could not have been written. Allegedly, the agent relied upon this misrepresentation; and the policy was *void ab initio.* No estoppel or misrepresentation can be inferred by any of the undisputed facts and no dispute exists as to any material fact. This record reflects only that plan beneficiaries disclosed their status as such to the insurers.

Finally, defendant Farmers Insurance Exchange protests that it should not have been named as a defendant in this case because it has not made any claims against plaintiffs. Thus, Farmers claims that there is no case or controversy as to it. The court finds that there is indeed no justiciable controversy as to Farmers Insurance Exchange because it has not filed any claims against plaintiffs. The court may not issue advisory decisions for hypothetical situations or instances in which a party anticipates a cause of action. *Caldwell v. Craighead,* 432 F.2d 213, 218 (6th Cir.1970) 28 U.S.C. §§ 2201-2202 cloaks this court with jurisdiction only "in a case of actual controversy within its jurisdiction. . . ." That controversy must exist

on the date the complaint is filed. Accordingly, the complaint as to Farmers Insurance Exchange is dismissed.

IT IS THEREFORE ORDERED that, for the reasons outlined above, M.C.L.A. § 500.3109a is preempted by ERISA and plaintiffs' motion for summary judgment is granted.

IT IS FURTHER ORDERED that Farmers Insurance Exchange's motion to dismiss is granted and the complaint as to Farmers Insurance is dismissed.

IT IS SO ORDERED.

APPENDIX B

Opinion of the Court of Appeals
November 13, 1987

(Decided November 13, 1987)

NOS. 86-1614, 86-1615, 86-1616
UNITED STATES COURT OF APPEALS,
SIXTH CIRCUIT
833 F.2d 85

NORTHERN GROUP SERVICES, INC., et al.,
Plaintiffs-Appellees,

v.

AUTO OWNERS INSURANCE COMPANY, et al.,
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

BEFORE: MERRITT and MARTIN, Circuit Judges, and BROWN, Senior Circuit Judge

MERRITT, Circuit Judge

[86] A group of automobile insurance companies challenge a ruling on summary judgment that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, preempted the Michigan No-Fault Automobile Insurance Act, Mich. Comp. Laws § 500.3109a, to the extent that the Michigan law allows policy provisions which conflict with ERISA plans. ERISA's preemption provision, 29 U.S.C. § 1144(a), provides in relevant part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this

> chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

The Michigan statute requires that no-fault automobile insurers offer coordination of benefits provisions, and state court interpretation of that law makes the liability under such no-fault coverage secondary to other health and accident coverage. The plaintiff plans make no-fault liability primary and their own liability secondary and hence conflict with the Michigan insurance law. We reverse, holding that the Michi[87]gan law is saved from preemption by the ERISA "savings" clause, 29 U.S.C. § 1144(b)(2)(A),

> Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities,

and is not barred by the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B),

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . .

The questions of preemption analysis and interpretation under the first preemption clause, § 1144(a), and the savings clause are straightforward and not particularly difficult. The questions under the "deemer" clause are more complex.

I. Proceedings Below

Several ERISA plans that provide employee health and medical benefits brought this declaratory action in the District Court seeking injunctive relief from medical expenses paid

under no fault insurance policies by those companies to those covered by the ERISA plans. The ERISA plans contain coordination of benefits provisions that purport to make the liability of the plans secondary to state mandated no-fault automobile insurance. The Masco plan for salaried employees provides:

> If your state has a no-fault motor vehicle law, the coverage required by the state is considered primary for motor vehicle related medical expenses. If you or a covered dependent incurs medical expenses as a result of a motor vehicle accident, those expenses should first be submitted to your motor vehicle insurance carrier. Any eligible expenses which are not paid by the carrier will then be considered for payment by the Masco Medical Plan. The Masco Medical Plan is considered secondary for no-fault motor vehicle expenses.

The automobile insurance companies defending the claims have issued no-fault automobile insurance contracts in accordance with Mich.Comp.Laws § 500.3109a. The Michigan law "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has 'other health and accident coverage.'" *Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 546, 383 N.W.2d 590, 594 (1986). In *Federal Kemper* the Supreme Court of Michigan determined that section 3109a imposed primary liability on a health insurer when the insured also had a no-fault policy with a coordination of benefits clause and the no-fault insurer charged lower premium rates. Relying on section 3109a and *Federal Kemper*, the automobile insurance companies have made claims against the employee benefit plans for reimbursement, asserting that they, not the plans, are secondarily liable.

In order to settle this confusion over the coordination of benefits between the plans and the statutorily required no-fault coverage, the plans and a plan administrator brought a declaratory action. After discovery, the parties made cross motions for summary judgment. The District Court held that ERISA preempted the Michigan law because the Michigan law "relate[d] to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). *Northern Group Services v. State Farm Mutual Automobile Insurance Co.*, 644 F.Supp. 535 (E.D.Mich.1986). Further, the Michigan law was not protected by the savings clause, § 1144(b)(2)(A), because the plans were excluded by the deemer clause, § 1144(b)(2)(B). Because the plans were protected by ERISA, Michigan could not regulate the benefits they provided. The District Court concluded that "[t]he Michigan No-Fault Automobile Insurance Act is preempted to the extent that it has an impact on the ERISA plans." *Id.* at 538. The Court granted plaintiffs' motion for summary judgment and denied defendants' cross motion.

II. "Relate To"

As was inevitable with such broadly phrased statutory language, the extent of [88] the preemption provision has been the subject of much litigation.

Shaw v. Delta Air Lines, 463 U.S. 85, 96-98, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490 (1983), made clear that a law "relates to" an employee benefit plan if it has "a connection or reference to such a plan." The Court based this reading not only on a plain meaning approach but on the expressed legislative intent giving the words "relate to" a broad scope. Id. at 97-98, 103 S.Ct. at 2900. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), held that a state law requiring that health insurers

provide mental-health-care benefits "clearly" relates to ERISA welfare benefit plans. *Id.* at 739, 105 S.Ct. at 2389.

In *Fort Halifax Packing Co. v. Coyne*, ____ U.S. ____, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), the Supreme Court further considered the meaning of the phrase "relate to any employee benefit plan." In *Fort Halifax* a Maine official sought to enforce the state statute requiring employers, in the event of a plant closing, to provide a one-time severance payment to employees not covered by express contract agreements providing for severance pay. The Court held that the Maine severance pay statute did not "relate to any employee benefit plan" under the ERISA preemption provision, 29 U.S.C. § 1144(a), and thus was not preempted. Relying on the meaning and underlying purpose of section 1144(a), the Court rejected Fort Halifax's argument that any state law pertaining to a type of employee benefit listed in ERISA, such as severance pay, necessarily regulates a plan and is preempted.

Section 1144(a), the Court noted, expressly states that state laws are superseded to the extent they "relate to any employee benefit *plan*." The Court said that the preemption provision "does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*'." *Id.* at 107 S.Ct. at 2215 (emphasis original). The Court observed that ERISA uses the words "benefit" and "plan" separately throughout and nowhere treats the two as synonymous. "Given the basic difference between a 'benefit' and a 'plan,' Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 2216.

The Court identified the purpose of the preemption provision: to allow plans to adopt a uniform scheme for coordinating complex administrative activities, unaffected by divergent regulatory schemes in different states. Congress was aware of the administrative realities faced by employee benefit plans,

and sought to "eliminat[e] the threat of conflicting or inconsistent State and local regulation." *Id.* (*quoting* 120 Cong.Rec. 29197 (1974) (remarks of Rep.Dent)). The Court explained that any employer who undertakes systematically to pay certain benefits assumes a number of obligations such as ascertaining eligibility, determining benefits, making payments, monitoring the availability of funds for benefit payments, and keeping records in compliance with reporting requirements:

> The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Id. Thus, ERISA's preemption provision was designed generally to "ensure [] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.* at 2217.

The analysis in *Fort Halifax* does not affect the result here. *Fort Halifax* held that a Maine state law requiring a *one-time* severance payment when a plant is closed did not "relate to" any *plan* because it imposed no continuing administrative obligation. The Court described the state-law [89] obligation as one "[t]o do little more than write a check." Under the *Fort Halifax* circumstances, preempting state law to clear the way for exclusive federal regulations would "in no way serve the overall purpose of ERISA," because "there would be nothing to regulate." *Id.* at 2218, 2220.

By contrast, the Michigan coordination-of-benefits law imposes not a one-time duty but rather a continuing and predictable obligation to coordinate benefits with the other insurance coverage of all ERISA beneficiaries. Affected ERISA administrators would be required to "foresee the need to make regular payments . . . on an ongoing basis," *Fort Halifax,* 107 S.Ct. at 2219 n. 9, and to make appropriate actuarial (and cost) adjustments.

In summary, the Michigan law conflicts directly[1] with the plan: it allocates obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan. Holding that this state law does not "relate to" the plan would run contrary to the plain meaning of the text and to the relevant case law and legislative history.

Because this state law "relates to" ERISA plans, we must proceed to see what effect the "savings" and "deemer" clauses have on preemption.

III. "Savings" and "Deemer" Clauses

The difficult problem in interpreting the preemption portion of ERISA § 514, 29 U.S.C. § 1144 is defining the scope of each of the three critical clauses so that each has meaning and so that benefit obligations are governed by a rational system of state law and federal common law. Congress indicated its intention only in a very general way and left to the federal courts the problem of developing on a case-by-case basis principles of preemption of state law.

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[1] The exception for "too tenuous, remote, or peripheral" regulation created in *Shaw,* 463 U.S. at 97 n. 17, 103 S.Ct. at 2900 n. 17, thus is inapplicable here. *Cf. Firestone Tire & Rubber Co. v. Neusser,* 810 F.2d 550, 553-56 (6th Cir. 1987).

If the first preemption clause, § 1144(a), is read restrictively, the "savings" and "deemer" clauses become unnecessary. Compounding the difficulty is a tendency in the legislative history of ERISA to conflate and confuse the three clauses. For example, an oversight report issued three years after the enactment of ERISA cites the need "to insure uniformity of regulation" by legislating preemption but then says:

> There was a recognition of the necessity for the preservation of some State activity in this field and certain limited exceptions were made to the broad preemption scheme. *In general these exemptions are designed to save State law as it applies to entities which are not employee benefit plans . . ., to the extent that such regulation does not relate to employee benefit plans.*
>
> • • •
>
> These exceptions are designed to delineate affirmatively the limits of the "field" preempted by section 514(a), and articulate a second, but distinctly subordinate, policy within the section of preserving state authority *insofar as it does not relate to any plan. . . .*

ERISA Oversight Report of The Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor, at 8-9 (1977) (emphasis added).

These subsequent legislators (or their staff) did not seem to recognize or consider the fact that the "savings" clause would not be necessary at all if it only saves state laws that do not "relate to" ERISA plans. The savings clause would not be necessary to save something that the preemption clause had not reached in the first instance. *See Metropolitan Life,* 471 U.S. at 739-40, 105 S.Ct. at 2389.

A. "Savings" Clause

After preempting state laws that "relate to" plans, the "savings" clause provides the qualification that preemption does not apply to a state law that "regulates insurance, banking, or securities." Like the mandated-benefits act at issue in *Metropolitan Life Insurance Co. v. Massachusetts,* the Michigan coordination of benefits law controls the terms of insurance contracts. [90] The Michigan law clearly "regulates insurance" within the meaning of the savings clause. This conclusion comports both with a common sense view of the statutory language and with a more formal assessment that the practice falls within the meaning of "business of insurance" covered by the McCarran-Ferguson Act. *Metropolitan Life,* 471 U.S. at 740–43, 105 S.Ct. at 2389-91.

In order to satisfy a common sense understanding of the phrase "regulates insurance," a state law must have not merely an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life Insurance Co. v. Dedeaux,* ____ U.S. ____, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987). The Michigan coordination of benefits law obviously is principally directed at various types of other-insurance coverage held by all of its residents who elect the coordination of benefits option that is mandated by § 3109a. Mich.Comp.Laws 500.3109a.

Three criteria have been identified as relevant to the McCarran-Ferguson Act determination:

> (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.

Metropolitan Life, 471 U.S. at 743, 105 S.Ct. at 2391 (quoting *Union Labor Life Insurance Co. v. Pireno,* 458 U.S. 119, 129, 102

S.Ct. 3002, 3008, 73 L.Ed.2d 647 (1982)). Like other courts that have applied these criteria to coordination-of-benefits or similar requirements, we find the first two of the three criteria easily satisfied. The practice of coordination of benefits spreads risk and regulates permissible terms of the insurance contract. *See, e.g., United Food & Commercial Workers v. Pacyga,* 801 F.2d 1157, 1161 (9th Cir.1986); *State Farm Mutual Insurance Co. v. American Community Mutual Insurance Co.,* 659 F.Supp. 635, 637 n. 2 (E.D.Mich.1987).

Although the scope of § 3109a extends beyond traditional insurance to encompass other types of "health and accident coverage" including Blue Cross and Blue Shield benefits and health maintenance organizations,[2] the third McCarran-Ferguson Act criterion also is substantially satisfied because coordination of benefits is aimed principally at different types of *insurance* coverage. *See LeBlanc v. State Farm Mutual Auto Insurance Co.,* 410 Mich. 173, 301 N.W.2d 775, 784–85 (1981).

B. "Deemer" Clause

The Michigan coordination of benefits law "regulates insurance" and therefore is encompassed by the savings clause. The final question becomes: what is the effect of the "deemer clause"?

1. The Problem of Self-Insuring Plans

Most judicial interpretation of the deemer clause as an exception to the savings clause has been confined to a distinction

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[2] *See, e.g., LeBlanc v. State Farm Mutual Automobile Insurance Co.,* 410 Mich. 173, 301 N.W.2d 775 (1981) (Medicare); *United States Fidelity & Guaranty Co. v. Group Health Plan,* 131 Mich. App. 268, 345 N.W.2d 683 (1983) (health maintenance organization); *Nyquist v. Aetna Insurance Co.,* 84 Mich.App. 589, 269 N.W.2d 687 (1978) (Blue Cross & Blue Shield), *aff'd,* 404 Mich. 817, 280 N.W.2d 792 (1979).

which makes the deemer clause applicable to self-insuring ERISA plans and makes it inapplicable to plans that purchase insurance. Even direct regulation of the content of insurance policies that an ERISA plan purchases is not barred by the deemer clause. Regulation of the insurance contract or of the insurer from which the plan buys its policy does not entail treating or deeming *the plan* as an insurer or as otherwise in the "business of insurance." *See Metropolitan Life,* 471 U.S. at 735 n. 14, 742 n. 18, 105 S.Ct. at 2387 n. 14, 2390 n. 14; *Michigan United Food & Commercial Workers Unions v. Baerwaldt,* 767 F.2d 308, 312-13 (6th Cir.1985) *cert. denied,* 474 U.S. 1059, 106 S.Ct. 801, 88 L.Ed.2d 77 (1986).

The *Metropolitan Life* Court appeared in dicta to assume that this distinction would leave insured plans "open to indirect regu-[91]lation" by state insurance laws while leaving self-insured plans unregulated. In *Metropolitan Life,* the Court upheld under the savings clause state laws which "mandate" that specific benefits be included in group health plans. No question was presented under the deemer clause. As an aside the Court observed:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747, 105 S.Ct. at 2393. At that point the Court dropped the following footnote:

> A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans: "To the extent that [certain programs selling insurance policies] fail to meet the definition of an 'employee benefit plan'

> [subject to the deemer clause], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H.R.Rep. No. 94–1785, p. 48. A bill to amend the savings clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon.

Id. at 747 n. 25, 105 S.Ct. at 2393 n. 25.

Our consideration of the deemer clause, thus, must answer two questions. First, are the plans at issue "insured"? Second, if a plan is not "insured," is state regulation of coordination of benefits under the plan totally barred by the deemer clause? In other words, is the deemer clause a total bar to state regulation of any insurance provision of a self-insured plan even though the deemer clause would not preempt state law if the plan is funded through the purchase of insurance?

There is no dispute that the Masco Plans are self-insured; the parties disagree about the status of the Highland plan, which is covered by stop-loss insurance. Appellee plans argue that the Highland Plan is "uninsured" because (1) the actual insured is the employer, Highland Appliance Co., and not the Plan; and (2) the insurer's liability comes into effect only when specified benefit ceilings are exceeded. Both arguments are without merit. Whether the actual insured is the employer or the ERISA plan, the stop-loss insurance is purchased to "provide benefits for plans subject to ERISA." *Metropolitan Life,* 471 U.S. at 738 n. 15, 105 S.Ct. at 2388 n. 15. That the Plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nonetheless insured. *See Baerwaldt,* 676 F.2d at 313.

The Masco plans, however, apparently are totally self-insured. Are they thereby totally immune from traditional

state insurance regulation? Upon full consideration of the statutory scheme, we conclude that they are not.

Although Congress delcared its express intention to generally preempt state law in the preemption clause, 29 U.S.C. § 1144(a), it equally expressly declared its intention to preserve state regulation of insurance in the savings clause, 29 U.S.C. § 1144(b)(2)(A). Therefore, in determining the scope even of express ERISA preemption, the general principle still applies that a court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life,* 471 U.S. at 740, 105 S.Ct. at 2389 *(Citing Jones v. Rath Packing Co.,* 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604 (1977)).

This presumption receives specific reinforcement from two subsections in § 514. ERISA section 514(d) says:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States. . . .

29 U.S.C. § 1144(d). This subsection provides an independent source of protection to state insurance regulation by including [92] in its coverage the McCarran-Ferguson Act, which says:

> The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business.

15 U.S.C. § 1012(a); *see Metropolitan Life,* 471 U.S. at 744 n. 21, 105 S.Ct. at 2392 n. 21; *see also Shaw,* 463 U.S. at 101 n. 22, 103 S.Ct. at 2902 n. 22.

Section 514(d) makes no specific reference to the McCarran-Ferguson Act. Section 514(b)(2)(B), however, by

using the phrase of art, the "business of insurance," makes clear that the scope of state insurance regulation saved by the "savings" clause must include the "business of insurance" as defined by the McCarran-Ferguson Act.

In the face of this redoubled statutory preservation of the principle favoring state regulation of insurance, it appears contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, "the presumption is against pre-emption." *Metropolitan Life,* 471 U.S. at 741, 105 S.Ct. at 2390; *see also Wadsworth v. Whaland,* 562 F.2d 70 (1st Cir.1977), *cert. denied,* 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978).

The legislative history behind the deemer clause is ambiguous. As the Court observed in *Metropolitan Life,* the preemption sections "are not a model of legislative drafting" because "while Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." 471 U.S. at 739–40, 105 S.Ct. at 2389.

Before conference, the House and Senate versions of the bill preempted only those state laws that related to the "fiduciary, reporting and disclosure responsibilities" of the Act or that related to "the subject matter regulated" by the Act. Both versions saved state insurance regulation, but neither contained a "deemer" clause until the House substituted the text of H.R. 12906 for that of H.R. 2 just prior to passage of the pre-conference House bill. *See* Subcomm. on Labor of the House Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., Legislative History of the Employee Retirement Income Security Act of 1974, at 2671, 2921. Before conference, the committee staff, noting the difference between the House and Senate versions on the "deemer" clause reported itself divided on whether "the House provisions should be adopted" and

recommended that, if it were, adoption be for only a limited period of time and subject to subsequent study. *Id.* at 5283. The conference version of the bill broadened preemption, retained the deemer clause without any time limit, and mandated Congressional study of "the effects and desirability of the Federal preemption of State and local law with respect to matters relating to pension and similar plans." 29 U.S.C. § 1222.

In 1977, the Activity Report of the House Committee on Education and Labor expressed the opinion that

> the "deemed" language was utilized to create an irrebuttable presumption that these plans are not insurance, trust companies, etc. for purposes of state regulation. As a drafting technique the "deemed" is used in section 514(b) not to *bar* the use of a legal fiction by the states but to *create* what may amount to a legal fiction in a given circumstance. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance, trust, or securities activities generally regulated by a state.

ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor, at 10 (1977) (emphasis in original). This *post hoc* explanation, while interesting, is entitled to little weight when it conflicts with a reasonable interpretation of a statute based on its text and its legislative history prior to enactment. *See Consumer Product Safety Commission v. GTE Sylvania,* 447 U.S. 102, 117-18 & n. 13, 100 S.Ct. 2051, 2060-61 & n. 13, 64 L.Ed.2d 766 (1980).

[93] Certain aspects of the legislative history imply that a main concern of Congress in adopting the final broad version of section 514 that emerged from the conference committee

was to avoid intentional — and perhaps pretextual — attempts by states to restrict the discretion of ERISA plans to engage in practices that otherwise would be permitted by federal law.[3] *See American Progressive Life & Health Insurance Co. v. Corcoran,* 715 F.2d 784, 787 (2d Cir. 1983). Neither intention nor pretext, however, is raised by the state regulation here.

2. State and Federal Interests

A conflict between two coordination of benefits clauses, as here, invokes a large body of substantive law that has developed over time to resolve such conflicts, law based on principles of restitution as applied in the insurance context. *See, e.g.,* 8A Appleman, *Insurance Law & Practice* §§ 4906-23; 44 Am.Jur.2d, *Insurance* §§ 1781-93. The Michigan legislature and courts simply have superimposed upon this body of law a reasonable policy judgment that a conflict between benefits available under no-fault and other benefits should be resolved in favor of the no-fault insurer. This resolution eliminates duplication of recovery by the insured and furthers the twin purposes of § 3109a to contain both auto insurance costs and health insurance costs. *See Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.,* 424 Mich. 537, 383 N.W.2d 590, 596 (1986).

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[3] *See Metropolitan Life,* 471 U.S. at 745-46 & nn. 23-24, 105 S.Ct. at 2392 & nn. 23-24. This view is reinforced by the language of the deemer clause itself, which protects ERISA plans from being "deemed" insurers or otherwise in the business of insurance by any state "purporting" to regulate insurance. 29 U.S.C. § 1144(b)(2)(B). Sponsoring senators expressed their satisfaction that states would be barred from frustrating Congressional intent by the "*guise* of state-enforced professional regulation" or by "state laws hastily *contrived* to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the federal regulatory scheme. *See* 12 Cong. Rec. 29,933 (Sen. Williams); 120 Cong.Rec. 29,942 (Sen. Javits) (emphases added).

Neither the principal purpose nor the main effect of the Michigan coordination of benefits law is to restrict the range of options open to ERISA plans. The State legislature and its courts simply have decided that medical expenses resulting from an auto accident should be paid first by those who have specifically insured the medical risk in the form of health and hospitilization coverage rather than by the no-fault insurance liability carrier. Auto no-fault coverage is compulsory, and the State therefore has a strong, legitimate interest in keeping down the costs of this coverage. This interest is not likely to be exercised in a parochial or discriminatory way. When there is multiple coverage, loss simply is first spread to entities other than no-fault insurers. ERISA plans are treated no differently than other entities providing "coverage."

In the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance. Put another way, should interstate uniformity in the coordination of a plan's benefits with other insurance benefits override a state's traditional interest in a uniform rule for allocating comparative liability among all insurers? Which principle of uniformity is the least disruptive and the most likely to create the orderly system of reliable benefits that Congress had as its object in enacting ERISA?

Exemption of the Masco Plan and other self-insurers from the Michigan rule of *Federal Kemper* would disrupt the State's ability to administer a uniform scheme of "other-insurance" or "coordination of benefits" law. Not only would exemption frustrate the goal of cost containment, it would also create unpredictability and possibly undermine the financial stability of no-fault insurers.

Against this injury to the State scheme, we must weigh the federal interest in uniformity of administration of ERISA plans. The question is whether ERISA plan provi[94]sions for coordination of benefits should receive a uniform national construction.

3. The Proper Role of Federal Common Law

One "uniform rule" would be simply to defer willy nilly to the provisions of the ERISA plan, an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial review. The other alternative would be for the federal courts to develop an entire body of federal common law to resolve "other insurance" disputes between ERISA plans and other insurers on a case-by-case basis — an approach that would be inefficient and uninformed by any well-defined independent federal interest.

Over the years states, including Michigan, have developed a substantial and complex body of common law and statutory principles to resolve questions of priority that arise when multiple coverage produces conflicts of the type presented in this case. This corpus of law embodies principles of restitution and risk allocation that have evolved from acquired state experience and expertise. Although these rules may be imperfect and display some minor variation from state to state, in the aggregate they nonetheless represent an interconnected and complex network of generally applicable laws with which the nation's insurers have grown familiar. *See, e.g.*, 8A Appleman, *Insurance Law & Practice* §§ 4906–23.

Although the drafters of ERISA clearly contemplated and invited the development of federal common law[4] to fill gaps

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[4] Sen. Javits remarked: "It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong.Rec. 29,942.

resulting from ERISA's broad preemption of state law outside the insurance field, it is less than clear that this would be a salutary development in an area that would overlap and inevitably conflict with established state insurance jurisprudence. In the absence of any particular federal interest in uniformity that would inform the development of federal common law on this issue, what federal common law we might develop surely would mostly parrot the principles already developed by the state courts. Moreover, application of a federal rule of common law here would trigger a substantial risk of "disrupt[ing] commercial relationships predicated on state law." *West Virginia v. United States,* ____ U.S. ____, 107 S.Ct. 702, 705, 93 L.Ed.2d 639 (1987) (quoting *United States v. Kimbell Foods, Inc.,* 440 U.S. 715, 729, 99 S.Ct. 1448, 1459, 59 L.Ed.2d 711 (1979)).

This entire scenario would undermine the general authority and autonomy the states now enjoy in their regulation of insurance. In view of the expressed intent of Congress and of the Supreme Court that ERISA should be read consistently with the policies underlying the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.,* there is strong reason to respect the policy choice and expertise of the state of Michigan in the area of coordination of benefits.

Accordingly, we read the "deemer" clause no more broadly than the underlying purpose of § 514 and of ERISA as a whole — the interests of national uniformity.[5]

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[5] *See* 120 Cong.Rec. 29,942 (remarks of Sen. Javits): "[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required — but for certain exceptions — the displacement of State action in the field of private employee benefit programs."

This approach better reconciles the competing national policies favoring (1) comprehensive federal regulation of employee benefit plans and (2) state primacy in the regulation of insurance. Nor is this approach necessarily inconsistent with the dicta in *Metropolitan Life* concerning insured versus self-insuring plans.[6] 471 U.S. at 740–41, 747, 105 S.Ct. at 2389–90, 2393. We [95] preserve a distinction between insured and self-insuring plans. Insured plans would be *per se* "open to indirect regulation." *Id.* at 747, 105 S.Ct. at 2393. Self-insuring plans would be subject to state regulation only when no independent federal interest in national uniformity exists to inform and guide the creation of federal common law. *See Mardan Corp. v. C.G.C. Music, Ltd.*, 804 F.2d 1454, 1457–58 (9th Cir.1986); *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 457, 77 S.Ct. 912, 918, 1 L.Ed.2d 972 (1957); *cf. Wilson v. Garcia*, 471 U.S. 261, 105 S.Ct. 1938, 85 L.Ed.2d 254 (1985).

Our reading of the savings and deemer clauses thus requires at a minimum that, for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance. When, as here, there is no demonstrated interest in national uniformity and preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally, the deemer clause does not bar regulation. To this limited degree,

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[6] In *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. at 1555, the Court construed the sweep of the savings clause as a whole and in light of the object and policy underlying ERISA, thus going beyond the meaning imposed merely by application of the McCarran-Ferguson Act factors. We take the same approach here to reconciliation of both the savings and deemer clauses.

self-insured ERISA plans so regulated are not excluded from the savings clause by the deemer clause; they are thus subject to state insurance regulation pursuant to the savings clause. The Michigan no-fault coordination of benefits rule is the type of insurance regulation of an ERISA plan that is not barred by the deemer clause. We find support for this result in *Employers Association v. New Jersey,* 601 F.Supp. 232 (D.N.J.) (state coordination of benefits not barred by the deemer clause), *aff'd mem.,* 774 F.2d 1151 (3d Cir. 1985) (post-*Metropolitan Life*); *contra State Farm Mutual Insurance Co. v. American Community Mutual Insurance Co.,* 659 F.Supp. 635 (E.D.Mich. 1987).

The judgment below is therefore reversed and the case remanded to the District Court for further proceedings not inconsistent with this opinion and with the Michigan law as enunciated in *Federal Kemper. See Federal Kemper,* 424 Mich. 537, 383 N.W.2d at 596 n. 10.

APPENDIX C

Order of the Court of Appeals
denying Petition for Rehearing en banc
December 30, 1987

No. 86-1614/5/6

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NORTHERN GROUP SERVICES, INC., et al.,
Plaintiffs-Appellees,

v.

STATE FARM MUTUAL AUTOMOBILE INS., CO., et al.,
Defendants,

AUTO OWNERS INSURANCE CO., et al.,
Defendants-Appellants.

ORDER

The Court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, an no judge of this Court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ John P. Hehman, Clerk

APPENDIX D

Relevant Statutory Provisions

I. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
29 U.S.C. Section 514

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

II. MICHIGAN NO-FAULT INSURANCE ACT M.C.L.A. § 500.3109a

500.3109a. Deductibles and exclusions relating to other health and accident coverage

Sec. 3109a. An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The

deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

87 1598

Supreme Court, U.S.
FILED
APR 22 1988
JOSEPH F. SPANIOL, JR.
CLERK

No.

In The
Supreme Court of the United States
October Term, 1987

NORTHERN GROUP SERVICES, INC., *et al.*,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
Respondents.

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

I.

Is a coordination of benefits provision in a self-insured ERISA Plan entitled to supremacy over a conflicting coordination of benefits provision in a no-fault automobile insurance contract?

II.

Does the Deemer Clause prevent application of State Insurance Laws to an ERISA Plan which purchases stop-loss insurance?

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	2
THE REASONS FOR OPPOSITION TO GRANTING OF WRIT	8
I. A Coordination of Benefits Provision In A Self-Insured ERISA Plan Is Not Entitled To Supremacy Over A Conflicting Coordination Of Benefits Provision In A No-Fault Insurance Contract And The Sixth Circuit Reached The Fair And Correct Result Based On The Overall Object of ERISA And The Peculiar Factual Circumstances Existing In This Case	8
II. The Stop-Loss Insurance Purchased By The Highland Plan Is An Integral Part Of The Plan And Constitutes Insurance Within The Meaning Of The Deemer Clause. The 9th Circuit Decisions To The Contrary Are Simply Incorrect	16
CONCLUSION	19

TABLE OF AUTHORITIES

CASES	PAGE
Auto Club v *Frederick & Herrud*, 145 Mich App 722, 377 NW2d 902 (1985)	5
Cotton v *General Motors Corp.*, 612 F. Supp. 948 (D.C. Mich 1985)	13
Farm Bureau Insurance v *H. Mann Insurance*, 131 Mich App 98, 345 NW2d 655 (1983)	4
Federal Kemper v *Health Insurance*, 135 Mich App 76; 351 NW2d 900 (1984), modified 424 Mich 537, 383 Nw2d 590 (1986)	5, 8, 12
Firestone Tire and Rubber, Co. v *Neusser*, 810 F.2d 550 (6th Cir. 1987)	15
Fort Halifax Packing, Co. v. *Coyne*, U.S. 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987)	9
Holliday v *Xerox Corp.*, 555 F. Supp. 51 (E.D. Mich 1982) affirmed 732 F.2d 548 (6th Cir. 1984), *cert denied* 469 U.S. 917, 125 S.Ct. 294, 83 L.E.2d 229 (1984)	13
Mary Free Bed Hospital v *INA*, 131 Mich App 105, 345 NW2d 658 (1983)	4
Metropolitan Life Insurance v *Mass.*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985)	9, 10
Michigan United Food and Commercial Workers Union v *Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert denied* 474 U.S. 1059, 106 S.Ct. 801, 88 L.E2d 777 (1986)	16
Moore v *Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986)	16
Northeast Dept. ILGWU v *Teamsters Local U. No.* 229, 764 F.2d 147 (3d Cir. 1985)	13

Pilot Life Ins. Co. v *Dedeaux*, U.S. 107 S. Ct. 1549, 95 L.Ed2d 39 (1987) 9, 16

Rebaldo v *Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert denied*, 472 U.S. 1008, 105 S. Ct. 2702, 86 L.E2a 718 (1985) 14

Shavers v *Attorney General*, 402 Mich 554, 267 NW2d 72 (1978)..... 4

Shaw v *Delta Airlines, Inc.*, 463 U.S.85, 103 S. Ct. 2890, 77 L.Ed2d 480 (1983) 14

U.S. Fid. & Guar. Co. v *GHP*, 131 Mich App 268, 345 NW2d 683 (1983)..... 12

United Food and Commercial Workers v *Pacyga*, 801 F.2d 1157 (9th Cir. 1986) 16

STATUTES:

Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 *et seq*..... 2

29 U.S.C. 1001(b) 8

29 U.S.C. 1104(1) 8

29 U.S.C. 1144..... 6, 9

Health Maintenance Organization Act, 42 U.S.C. 300 e-9(a)(1)(B) 12

McCarran-Ferguson Act, 15 U.S.C. 1011 9

Section 3109a of the Michigan No-Fault Insurance Act, M.C.L.A. 500.3109a 2, 3, 4, 7, 9, 10, 11, 12, 14, 15

In the
Supreme Court of the United States
October Term, 1987

NORTHERN GROUP SERVICES, INC., *et al.*,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
Respondents.

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

Respondent prays that this Court deny the petition for a writ of certiorari to review a judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered on November 13, 1987.

STATEMENT OF THE CASE

Petitioners Masco Industries, Inc. Employees' Benefit Plan for Hourly Employees of Forming Technology, Masco Industries, Inc. Employees' Benefit Plan for Salaried Employees, Masco Industries, Inc. Self-Funded Employee Benefit Plans (Masco Plans) and Highland Appliance Company's Medical Benefit Plan (Highland Plan) are employer funded health benefit plans formed under the Employee Retirement Income Security Act of 1974 (ERISA). 29 U.S.C. 1001 *et seq.* Northern Group Services and Highland Appliance Company are Michigan corporations. Masco Industries, Inc. is not a Michigan corporation but is qualified to do business in Michigan. There are approximately 5,000 employees in the Masco Plans with participants in all 50 states and approximately 2,000 employees in the Highland Plan with participants in at least 4 states. All of the Plans are administered by Northern Group Services, a third-party administrator. In addition to the Masco Plans and the Highland Plan, Northern Group Services administers approximately 50 other ERISA Plans. Of these 50 Plans, approximately 90 percent purchase stop-loss insurance. Mr. William D. Alcott, III, the President of Northern Group Services, estimates that, nationally, 90 percent of ERISA Plans have some kind of insurance. The Highland Plan is an example of an ERISA Plan which purchases stop-loss insurance. The Masco Plans, however, are self-insured, there being no insurance coverage at all with respect to these Plans. Both the Masco Plans and the Highland Plan have a coordination of benefits provision which the Plans claim makes the coverage of the Plans excess over any no-fault auto insurance coverage.

The Auto Club Insurance Association, a Michigan no-fault insurance carrier, offers to its insureds coordinated benefits coverage at a reduced premium in accordance with the requirements of M.C.L.A. 500.3109a which provides as follows:

> "An insurer, providing personal protection benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health

and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the Commissioner and shall apply only to the benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household."

When an insured elects to buy coordinated medical benefits coverage, he pays a reduced premium. In consideration of the reduction of premium, the Auto Club Insurance Association is allowed by M.C.L.A. 500.3109a to insert a coordination of benefits provision in the insurance contract. The coordination of benefits provision in the Auto Club Insurance Association's contract makes other health insurance or health coverage primary. All of the coordination of benefits provisions in the Masco Plans, the Highland Plan and the Auto Club Insurance Association policy are known as "excess" provisions.

When an eligible member of either the Masco Plans or the Highland Plan is injured in an automobile accident and the eligible employee has automobile insurance containing a coordinated medical benefits provision with the Auto Club Insurance Association, a dispute arises as to which coverage affords primary medical benefits because of the conflict between the "excess" provisions in the Masco Plans and the Highland Plan with the "excess" provision in the Auto Club Insurance Association policy. It must be remembered that the conflict arises only when the employee purchases no-fault insurance with a coordinated benefits provision. If the employee purchases a full coverage no-fault insurance policy, i.e. one that does not contain a coordination of benefits provision, then there is no conflict between the no-fault insurance contract and the ERISA Plan and the no-fault carrier would pay primary benefits.

The ultimate problem existing between the Masco Plans and the Highland Plan and no-fault insurers in Michigan is how the conflict between the coordination of benefits provisions in the Plans and insurance contract should be resolved.

The development of this conflict should be put in historical prespective.

The Michigan Supreme Court grappled with the constitutionality of Michigan's No-Fault Law in *Shavers* v *Attorney General*, 402 Mich 554, 267 NW2d 72 (1978). Because of the compulsory nature of Michigan's no-fault insurance, the Michigan Supreme Court examined the due process requirements of both the State and Federal Constitutions and concluded that the constitutionality of the Michigan No-Fault Statute was inexorably dependent on whether no-fault insurance was available at fair and equitable rates. *Shavers* at p. 599.

In 1974 Michigan enacted M.C.L.A. 500.3109a in a further attempt to reduce no-fault automobile insurance premiums.

A few years ago, the health coverage industry in Michigan, en masse, began adding provisions in health care plans and policies indicating that the coverage provided by the plan or policy was excess coverage if the person had no-fault automobile insurance. Obviously, this was an attempt on the part of the health coverage industry to shift the costs for medical expenses arising out of automobile accidents to the no-fault automobile insurance industry. When a particular person had a coordinated medical benefits provision in his or her no-fault automobile insurance policy and the person also had a health coverage plan or policy which also had a coordinated benefits provision, a conflict arose as to which of the two coverages would be primary.

Also, within the last few years the law in Michigan relating to conflicting "coordination of benefit" clauses came under scrutiny by the Michigan Appellate Courts. In *Farm Bureau Insurance* v *H. Mann Insurance*, 131 Mich App 98, 345 NW2d 655 (1983) (escape clause vs pro-rata clause) and in *Mary Free Bed Hospital* v *INA*, 131 Mich App 105, 345 NW2d 658 (1983) (escape clause vs excess clause), the Michigan Court of Appeals adopted the Lamb-Weston rule

regarding resolution of conflicting "coordination of benefit" clauses. If a conflict exists between the two clauses in the policies, i.e. each clause claiming the other is primary in coverage, and if each policy would provide coverage for the loss if the other policy did not exist, the Lamb-Weston rule states that both clauses should be disregarded and declared to be mutually repugnant and the coverage of both policies is shared on a pro-rata basis. These two cases just mentioned dealt with *non no-fault* insurance policies. One year later, the Court of Appeals applied the Lamb-Weston rule, for the first time, to a conflict between a health insurance carrier and a no-fault insurance carrier. See *Federal Kemper* v *Health Insurance*, 135 Mich App 76; 351 NW2d 900 (1984), modified 424 Mich 537, 383 NW2d 590 (1986). While the *Kemper* decision was being appealed to the Michigan Supreme Court, many, if not all, health insurance carriers and no-fault insurance carriers began to share losses on a pro-rata basis consistent with the then existing Michigan Law.

Then in 1985, the Michigan Court of Appeals decided *Auto Club* v *Frederick & Herrud*, 145 Mich App 722, 377 NW2d 902 (1985). The Court examined the legislative intent surrounding the enactment of M.C.L.A. 500.3109a and concluded that the purpose of the statute was to prevent duplication of benefits and to keep auto insurance premiums and health care costs to a minimum. To further the intent of the Legislature, the *Frederick & Herrud* Court, on public policy grounds, held that the health insurance carrier owed primary benefits and the no-fault insurance carrier owed only secondary benefits. Finally, the *Frederick & Herrud* analysis was approved and adopted by the Michigan Supreme Court in 1986. See *Kemper, supra*.

However, following the *Frederick & Herrud* decision, no-fault insurance carriers began demanding 100 percent reimbursement from health coverage providers. The usual practice was for the no-fault insurance carrier to pay the entire amount of the medical benefits and then seek reimbursement from the other health coverage provider. The problem caused by

the *Frederick & Herrud* case prompted Northern Group Services, Inc. to file this instant litigation, according to its President, Mr. William D. Alcott, III.

Northern Group Services, Inc., the Masco Plans and the Highland Plan filed an action in the Federal District Court asking the Court to declare that M.C.L.A. 500.3109a, and the Court decisions interpreting that statute, was pre-empted by ERISA, 29 U.S.C. Sec. 1144. This statute has three parts: pre-emption clause, savings clause, and deemer clause.

> "Except as provided in sub-section (b) of this section, the provisions of this sub-chapter and sub-chapter III of this chapter shall supercede any and all State Laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. Sec. 1144(a)

> "Except as provided in sub-paragraph (B) nothing in the sub-chapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities. . . ." 29 U.S.C. Sec. 1144(b)(2)(A)

> "Neither an employee benefit plan . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. Sec. 1144(b)(2)(B)

While acknowledging the conflict in the coordination of benefits provisions between the Masco Plans, Highland Plan and the automobile no-fault insurance contracts, petitioners contended that ERISA made their coordination of benefits provision supreme over the one in the no-fault insurance contract. The Respondents answered by contending that the dispute was one of *contractual* interpretation and not ERISA pre-emption but even if ERISA pre-emption applied, the contract provisions would still exist and the conflict between them had to be resolved. The problem was what law should be used to resolve the conflict. Respondents contended that Michigan law should be used to resolve the conflict. Since

there is no Federal common law of contract, the Federal Court should look to state law and, the Respondents contended, even the public policy of the state should be considered. In this case, it seemed even more appropriate to apply Michigan law since both the Masco Plans and the Highland Plan chose Michigan law for interpretation of the Plan provisions. The Highland Plan has a provision stating the following:

> "The Plans shall be interpreted under the laws of Michigan." (J.A. 579)

The Masco Plans have a similar provision which states as follows:

> "To the extent not inconsistent with Federal Law, the Plan shall be interpreted under the laws of Michigan." (J.A. 650)

Repsondents contended that, under both Federal common law and the Plans choice of law provisions, Michigan law should be used to resolve the conflict in the coordination of benefits provisions.

Furthermore, as to the Highland Plan, Respondents contended that even if ERISA pre-emption applied, that M.C.L.A. 500.3109a was saved from pre-emption by the insurance saving section of the ERISA pre-emption statute and that the Highland Plan was subject to insurance law regulation because the Highland Plan had purchased stop-loss insurance.

The District Court granted summary judgment to petitioners taking the position that M.C.L.A. 500.3109a was pre-empted and that neither Plan was insured. The Court resolved the conflict in the coordination of benefits provisions by equating ERISA pre-emption with surpremacy and held that the no-fault automobile insurance coverage was primary to the coverage provided by the Masco Plans and the Highland Plan.

The Sixth Circuit Court of Appeals reversed that lower court's decision, holding that Michigan law as enunicated in

the *Federal Kemper* case controlled. Specifically, the Sixth Circuit found that pre-emption applied and that M.C.L.A. 500.3109a was saved from pre-emption by the insurance savings provisions of the ERISA pre-emption statute. The Court further determined that the Highland Plan was an insured Plan. As to the Masco Plans which were self-insured, the Court concluded that the deemer section of the ERISA Pre-emption Statute did not bar the application of Michigan law relating to coordination of benefits provisions.

REASONS FOR OPPOSITION TO GRANTING OF WRIT

I.

A COORDINATION OF BENEFITS PROVISION IN A SELF-INSURED ERISA PLAN IS NOT ENTITLED TO SUPREMACY OVER A CONFLICTING COORDINATION OF BENEFITS PROVISION IN A NO-FAULT INSURANCE CONTRACT AND THE SIXTH CIRCUIT REACHED THE FAIR AND CORRECT RESULT BASED ON THE OVERALL OBJECT OF ERISA AND THE PECULIAR FACTUAL CIRCUMSTANCES EXISTING IN THIS CASE.

Congress enacted ERISA to protect the *interest of participants* in employee benefit plans. 29 U.S.C. Sec. 1001(b). In fact, the fiduciary of an ERISA Plan is mandated to discharge his duties solely in the *interest of the participants* and beneficiaries. 29 U.S.C. Sec. 1104(1). So in looking at the issues in this case, it must be determined what is in the best interest of those residents of Michigan who are employees of Masco and Highland and participants in the employers' ERISA Plan remembering that only a portion of the 5,000 Masco employees and the 2,000 Highland employees who are members of the Plan are actually Michigan residents.

In resolving ERISA pre-emption issues, the Court should look to see if the overall purpose of ERISA would be served

by pre-emption. *Fort Halifax Packing, Co.* v *Coyne*, ____ U.S. ____, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987). Each section of the ERISA pre-emption statute, 29 U.S.C. Sec. 1144 (pre-emption clause, savings clause, deemer clause) must be given meaning considering the overall purpose of the object and policy underlining ERISA. Specifically, the savings clause should be interpreted not only with a common sense view and the case law under the McCarran-Ferguson Act, 15 U.S.C. Sec. 1011 *et seq.* but also the role of the saving clause in ERISA as a whole. See *Pilot Life Ins. Co.*v *Dedeaux*, ____ U.S. ____, 107 S.Ct. 1549, 95 L.Ed.2d 39, (1987).

The Sixth Circuit concluded that pre-emption applied since M.C.L.A. 500.3109a "related to" the Masco Plans and the Highland Plan. However, the Sixth Circuit also determined that M.C.L.A. 500.3109a was saved from pre-emption under the McCarran-Ferguson criteria enunciated in *Metropolitan Life Ins.* v *Mass.*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). With respect to the Masco plans which are self-insured, the Sixth Circuit then analyzed the deemer clause in light of the object of ERISA as a whole and balanced that object with the strong public policy of state regulation of insurance. The balancing of the competing interests by the Sixth Circuit was necessitated, in part, because there is no Federal law, statute or otherwise, which governs or relates to coordination of benefits provisions in ERISA Plans.

Because the Masco Plans are self-insured, does the deemer clause prohibit any Michigan law from affecting the Masco Plans? First of all one must ask why the word "purporting" is in the deemer clause but is not in the savings clause. It must be considered that Congress intended something specific by the use of the word "purporting." The Sixth Circuit opinion recognized that the use of the word "purporting" was designed to prevent the states from indirectly regulating an ERISA Plan by guise, pretext or some other devious legislation. Such is not the case here. M.C.L.A. 500.3109a was not enacted to specifically regulate the content of welfare benefits provided by ERISA. In fact, this fact distinguishes

this case from most other ERISA pre-emption cases which deal with mandated benefit statutes.

Petitioner argues that the Sixth Circuit opinion prevents a uniform application of the ERISA Plan. While uniformity was a goal in ERISA, this uniformity was still modified by the countervailing interests of continued state regulation of insurance. In other words, possible lack of uniformity in ERISA Plans was acknowledged and accepted. As the U.S. Supreme Court noted in *Metropolitan*, at p. 2393, some national ERISA Plans lack uniformity because of the problems encountered in entering local markets to purchase insurance but the Court further noted that "[s]uch disuniformities, however, are the inevitable result of congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of this policy choice must be directed at Congress."

Implicit in the petitioner's argument is the suggestion that uniformity now exists in the Masco Plans. Yet, that is not true. While the Masco Plans are uniform in benefits provided, i.e. hospital and surgical benefits, the Plans have never been uniform in the *amounts* of benefits paid. M.C.L.A. 500.3109a does not affect the uniformity of benefits offered by the Plans but merely affects the amounts paid by the Masco Plans, which amounts have never been uniform anyway. Assume that three Masco employees are involved in automobile accidents, one living in Florida, one living in Illinois and one living in Michigan and all incurring medical expenses of $100,000. Since Florida has a $10,000 limitation in its no-fault insurance coverage, the Masco Plan would pay $90,000 of that employee's medical expenses. Since Illinois is not a no-fault state, the Masco Plan would pay $100,000 of the Illinois employee's expenses. However, since the Michigan employee has unlimited medical expense coverage under no-fault, the Masco Plan would pay nothing towards the $100,000 in medical expenses.

Masco argues that it wants only to look to the plan documents (except where it would be unfavorable to the Plans, i.e. following the choice of law provision) to determine how

the plan should be administered and, yet, it must look outside the plan anyway to determine the laws of the various states vis-a-vis no-fault insurance coverage and whether or not the employee, in fact was covered by the no-fault insurance contract.

Even though the amounts paid by the Masco Plans differ depending on the availability of no-fault insurance coverage to the employee, the Masco Plans do not rate or underwrite that fact. The cost per plan participant is the same whether or not the person has no-fault coverage or not. In effect, the Michigan participants in the Masco Plans are subsidizing the plan participants in the other 49 states. How is this in the best interest of the Michigan participants in the Masco Plans?

It is commonly understood that the employer pays for the employee's health benefit plan but the employee pays for his or her own automobile insurance coverage. This case is no exception. M.C.L.A. 500.3109a merely requires the no-fault insurance carrier to offer a choice to the insured to purchase full no-fault insurance coverage or to purchase coordinated benefits coverage for a reduced premium. It is the employee's choice. Yet, if the employee does not have other health coverage, he is not entitled to get coordinated benefits coverage and pay a reduced premium. The Masco Plans, by taking the position that their plan is excess over Michigan no-fault coverage, are requiring their employees to pay more money for automobile insurance and thereby, indirectly, supplementing the cost of the ERISA Plan without disclosure to the employee. So not only does the Michigan Masco Plan participant subsidize the Plan in the first place by having to buy no-fault insurance coverage, but the Masco Plans are requiring the Michigan participants to subsidize the Masco Plans even further by forcing the employee to buy full no-fault insurance coverage rather than coordinated benefits coverage and, thus, pay a higher premium for his or her automobile insurance coverage.

In lieu of participation, in the Masco Plans, Masco Corporation offers its employees the option of joining a health

maintenance organization. This option is required by the Federal Health Maintenance Organization Act, specifically 42 U.S.C. 300 e-9(a)(1)(B). Masco Corporation pays the cost of the health maintenance organization membership. HMOs are clearly within the purview of M.C.L.A. 500.3109a and the coverage of the HMO would be considered primary over Michigan no-fault coverage. See *Kemper, supra* and *U.S. Fid and Guar Co.* v *GHP*, 131 Mich App 268, 345 NW2d 683 (1983). The Masco Corporation employee with HMO coverage would be allowed to buy a no-fault insurance policy with a coordinated benefits provision and would get a reduced premium. However, according to the petitioners, an employee of the Masco Corporation who chooses the ERISA Health Plan would have to pay more for the automobile insurance by buying full coverage instead of coordinated benefits coverage. It doesn't make common sense to allow Michigan's Coordination of Benefits Law to affect the coverage of some employees of Masco Corporation (those with HMO coverage) and not affect the health coverage of other employees of Masco (those who chose the ERISA Plan).

The Masco Plans are really contracts providing certain health care benefits just as the no-fault automobile insurance policy is a contract providing certain benefits. The Masco Plans have a coordination of benefits provision which is in conflict with the coordination of benefits provision in the automobile insurance policy. These are really irreconcilable contractual provisions. The same type of conflict could exist completely apart from M.C.L.A. 500.3109a. In fact, a whole body of law has developed throughout the country relating to the resolution of conflicting coordination of benefits provisions. How would the petitioners resolve the conflict in coordination of benefits provisions with an insurance policy providing medical benefits coverage in a non-no-fault state, like Illinois, for example? Would the Masco Plans take the position that its provision is supreme over the insurance contracts provisions? Under what color of right could the Masco Plans claim to be supreme over an insurance contract

provision not mandated by any law? So what difference does it make that a Michigan coordination of benefits provision in a no-fault policy is mandated by law?

The Masco Plans contemplated that conflicts and questions would arise regarding interpretation of various plan provisions. Why else would a choice of laws provision be inserted in the plans? What would the Masco Plans do if the participant was also covered by another ERISA Plan. Masco Plans claim their provision is supreme and entitled to enforcement. But can't the same be said for the other ERISA Plan? This very problem was dealt with in *Northeast Dept. ILGWU* v *Teamsters Local U. No. 229*, 764 F.2d 147 (3d Cir., 1985). *Northeast* dealt with a dispute between two ERISA Plans over which coordination of benefits provision took precedence. One plan had an escape clause and the other had an excess clause. In order to resolve the conflict between these two clauses, the Court noted that the Federal common law would control. However, since there was no Federal common law relating to coordination of benefits clauses, the Court had to look to state law for guidance. The Court examined the state law and recognized that the states had a strong policy against escape clauses. The Court adopted the state law and declared void the escape type coordination of benefits provision and required that ERISA Plan to pay primary benefits.

A similar result was reached relating to contract law in *Cotten* v *General Motors Corp.*, 612 F. Supp. 948 (D.C. Mich 1985) and *Holliday* v *Xerox Corp.*, 555 F. Supp. 51 (E.D. Mich 1982), affirmed 732 F. 2d 548 (6th Cir.), *cert denied* 469 U.S. 917, 105 S. Ct. 294, 83 L.E. 2d 299 (1984). These cases stand for the proposition that contract actions are not pre-empted by ERISA. But even if state law relating to contract was pre-empted by ERISA, the contract must be construed in accordance with Federal law and since there isn't any substantial body of Federal law of contract, the state law will be looked to as a guide. In like fashion, Michigan law relating to coordination of benefits clauses is not pre-empted

by ERISA but rather is used as a guide. But in the case of the Masco Plans, and the Highland Plan, Michigan law is not only a guide but should be controlling because of the choice of law provisions incorporated in the Plans.

The Sixth Circuit recognized the irreconcilable conflict between the coordination of benefits clause but rejected the adoption of a uniform rule of deferring willy-nilly to the provisions of the ERISA Plan. Even petitioners did not contemplate such a rule. Otherwise, why insert a choice of law provision?

The Sixth Circuit also rejected a case by case development of Federal common law on the resolution of conflicted coordination of benefits provisions. After recognizing the substantial body of state law already existing on the subject, the Court concluded that any rule would merely parrot the state law anyway.

The fact is that the Sixth Circuit was confronted with such a unique issue relating to ERISA law that it did not readily lend itself to analysis under traditional pre-emption cases. The Court merely balanced the interests of the parties and the competing statutes to reach a fair and equitable rule. While the Court centered on the deemer clause and concluded that it did not bar application of Michigan Insurance Laws, the Court could have reached the same result by concluding the M.C.L.A. 500.3109a did not "relate to" the ERISA Plans within the intent and purpose of the ERISA statute. This latter approach is supported by the U.S. Supreme Court itself as noted in *Shaw* v *Delta Airlines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983). Everything that impacts an ERISA Plan should not be considered as "related to" the Plan for purposes of ERISA pre-emption. A line has to be drawn somewhere and the drawing of the line is based on the real purpose and intent of ERISA and other competing statues and interests. Mere economic impact on a Plan is not sufficient to require pre-emption. *Rebaldo* v *Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert denied*, 472 U.S. 1008, 105 S.Ct. 2702, 86 L.Ed.2d 718 (1985). Michigan could

repeal its no-fault law and a repeal of this law would have an economic effect on the Masco Plans. Does it really make a difference that the same economic result occurs if Michigan's law regarding coordination of benefits provisions is followed?

The fact that the Sixth Circuit in this case rejected the "related to" approach which it had recognized in *Firestone Tire and Rubber, Co.* v *Neusser*, 810 F.2d 550 (6th Cir. 1987) is not really material. The Sixth Circuit balanced all the competing interest and reached the right result through a construction of the deemer clause when it could very well have balanced the same competing interest and concluded that M.C.L.A. 500.3109a did not relate to the Masco Plans and the Highland Plan within the meaning and the purpose behind ERISA pre-emption.

ERISA pre-emption flys in the face of due process standards that are invoked by compulsory automobile insurance. Pre-emption in this case would increase the cost of automobile insurance and affect the availability of insurance at fair and equitable rates. The purpose of ERISA must be balanced by this constitutional due process standard.

Petitioners claim that the Sixth Circuit opinion relating to self-insured plans has widespread ramifications. Yet it must be remembered that only 10 percent of all ERISA Plans are self-insured. Furthermore, the Sixth Circuit opinion is really related to a very narrow issue — resolution of conflicting coordination of benefits provisions. The impact of the Sixth Circuit opinion is really primarily felt in Michigan where it was intended to be felt. What other state has such a broad no-fault scheme as Michigan with the strong public policy of reducing health care costs and keeping automobile insurance premiums to a minimum?

While said in a different way from that requested by Respondents, the Sixth Circuit reached the same fair and correct result justified by the unique circumstances of this case.

II.

THE STOP-LOSS INSURANCE PURCHASED BY THE HIGHLAND PLAN IS AN INTEGRAL PART OF THE PLAN AND CONSTITUTES INSURANCE WITHIN THE MEANING OF THE DEEMER CLAUSE. THE 9TH CIRCUIT DECISIONS TO THE CONTRARY ARE SIMPLY INCORRECT.

This Court has already considered whether stop-loss insurance is insurance to the extent that the deemer clause does not bar application of state insurance laws. See *Michigan United Food and Commercial Workers Union* v *Baerwaldt*, 767 F.2d 308 (6th Cir.,1985), *cert denied* 474 U.S. 1059, 106 S.Ct. 801 88 L.Ed2d 777, (1986). *Baerwaldt* is even more significant since it dealt with a mandated benefit statute and allowed direct regulation of an ERISA Plan which had purchased stop-loss insurance. In the instant case, the Highland Plan has stop-loss insurance and application of Michigan laws relating to coordination of benefits only *indirectly* affects the Plan.

The 9th Circuit's position regarding stop-loss insurance is incorrect. *Moore* v *Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986) held that the policy in question was not "insurance" within the meaning of the deemer clause since the aggregate deductible of the stop-loss insurance coverage had never been reached. In *United Food and Commercial Workers* v *Pacyga*, 801 F.2d 1157 (9th Cir. 1986) the Court held that the stop-loss insurance in question was not insurance within the meaning of the deemer clause since the insurance did not pay the participants directly but rather reimbursed the plan for amounts expended over the deductible limit.

First of all, the complete decision in *Moore* and *Pacyga* is not any longer the law in the 9th Circuit because of the standards later set by the U.S. Supreme Court in *Dedeaux* in analyzing whether or not a law is one which regulates the "business of insurance." Secondly, the 9th Circuit's position

that stop-loss insurance does not make an ERISA Plan an insured plan is simply incorrect. The essence of insurance is the transferring of a risk, the elimination of uncertainty. Insurance isn't only insurance when it pays a claim. It is the protection and security afforded by the contract in the first place that makes it insurance. Insurance is a question of status, not degree.

Insurance follows the law of large numbers. Depending on the peril involved and the number of exposures, it can accurately be predicted how many losses will be sustained in a certain period of time. However, it cannot be determined which people will sustain a particular loss. Through insurance, with everyone paying a small premium, those people who sustain a loss are indemnified. There is nothing magical about the application of this simple principle of the law of large numbers. The vast majority of people who purchase insurance never have a loss and their premiums indemnify those who do have losses. If 95 percent of insureds never have a loss, does that mean that they are not insured? If a person has a deductible, does that mean that he or she is not insured? If a person has a deductible and sustains a loss which does not exceed the deductible, does that mean that that person is not insured? Why should ERISA Plans which purchase stop-loss insurance be considered uninsured. Even if the deductibles are large, the principle is the same as for one who has a $500 deductible on his automobile collision coverage. One insures losses that one cannot afford to incur. The Highland Plan purchased stop-loss insurance to insure against losses which the Highland Plan couldn't afford to incur or was not willing to incur.

The stop-loss insurance purchased by the Highland Plan is an integral part of the Highland Plan as demonstrated by the following documents:

(a) The Preamble in the Highland Plan states the intention of Highland Appliance Company to enter into insurance contracts for specific and aggregate stop-loss protection with respect to the Plan and that this agree-

ment to get insurance, among other agreements, is incorporated together with the benefit's document and *those things together constitute the Plan*. (J.A. 546)

(b) The reinsurance policy provides benefits in accordance with the plan and the plan itself is made part of the reinsurance agreement. (J.A. 597)

(c) Highland Appliance Company's reinsurer is Northwestern National Life Insurance Company. The policy insured by Northwestern National Life Insurance Company is a "group" policy even though Highland Appliance Company is the named insured. (J.A. 611)

(d) Since Highland Appliance Company is the policy holder under the Northwestern National Life Insurance Company policy and pays all the costs, *all eligible employees must be insured*. (J.A. 613)

Query: Would the Highland Plan exist at all if stop-loss insurance was not available?

The insurance purchased by the Highland Plan is woven into and made a part of the Plan itself. The Highland Plan is insured within the meaning of the deemer clause and is subject to state insurance law regulation.

CONCLUSION

Based on an overall view and balancing of the competing constitutional, statutory, and individual interests and because of the choice of law provisions in both the Masco Plans and the Highland Plan, the result of the Sixth Circuit decision was correct. This Court should deny the Petition for Writ of Certiorari.

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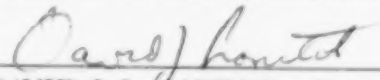
BY: 

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DATED: April 19, 1988

No. 97-1598

In The
Supreme Court of the United States
October Term, 1997

NORTHERN CIRCUIT SERVICES, INC., *et al.*,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
Respondents.

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMICUS CURIAE THORN APPLE VALLEY, INC. IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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TABLE OF CONTENTS

PAGE

Motion For Leave To File Brief of Amicus Curiae Thorn Apple Valley, Inc., in Support of Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit 1

Brief of Amicus Curiae Thorn Apple Valley, Inc., in Support of Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit 5

No. 87-1598

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1987

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Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
Respondents.

MOTION FOR LEAVE TO FILE BRIEF OF AMICUS CURIAE, THORN APPLE VALLEY, INC., IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

Thorn Apple Valley, Inc., respectfully moves for leave to file the accompanying brief of *amicus curiae* in support of the petition for writ of certiorari.

(1) Thorn Apply Valley, Inc. ("TAV"), is a Michigan-based meat packing company. It employs approximately 2,500 employees at production facilities located in Michigan and North Carolina, and at various sales and distribution facilities located in these and approximately 10 other states. Having annual sales of in excess of $500 million, TAV's effect upon interstate commerce is clear and significant.

(2) Virtually all employees of TAV, in all states in which it employs employees, are covered under one of approximately 15 self-insured and self-administered medical benefits plans sponsored by TAV. Most of these plans were the product of collective bargaining. All of them provide that when a plan beneficiary is involved in an automobile accident and has automobile insurance coverage available, "the auto insurance carrier will be primary."

(3) TAV's plans are and have been extensively involved in litigation in Michigan state courts with Michigan automobile insurance carriers over claims by the carriers for reimbursement from the plans for the carriers' payment of auto accident-related medical benefits to plan beneficiaries. These claims have been brought by the carriers under Michigan's common law of subrogation. In this litigation, TAV has contended, *inter alia*, that the carriers' reimbursement claims against the plans are preempted by ERISA.

(4) The claims which respondents threatened to bring against petitioners, and which caused petitioners to seek declaratory and injunctive relief from the district court, are identical to the claims that the automobile insurance carriers have brought and are bringing against TAV. The claims themselves, not merely the statutory policy arguments supporting the insurance carriers' interpretation of how the claims should be resolved, are directly preempted by ERISA. Petitioner does not, however, directly urge that the underlying threatened claims themselves are preempted, apart from its contention that the Michigan doctrines of construction which will be invoked to resolve those claims are preempted.

(5) ERISA's preemption of the claims which respondents threatened to bring against petitioners is clear under this Court's recent decision in *Pilot Life Insurance Co.* v *Dedeaux*, 481 U.S. ____, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). This fact is directly relevant to the disposition of this case.

(6) TAV has sought and was refused consent by respondents to file the accompanying brief of *amicus curiae*. Nonetheless, TAV respectfully submits that the significant issues raised in the accompanying brief, which have not been presented by the parties, warrant this Court's consideration.

Respectfully submitted,

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No. 87-1598

In The
Supreme Court of the United States
October Term, 1987

NORTHERN GROUP SERVICES, INC., *et al.*,
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v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
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BRIEF OF AMICUS CURIAE THORN APPLE VALLEY, INC. IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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TABLE OF CONTENTS

	Page
INDEX OF AUTHORITIES	ii
INTEREST OF AMICUS CURIAE	1
ARGUMENT	3
SUMMARY OF ARGUMENT	6
CONCLUSION	7

INDEX OF AUTHORITIES

	Page
CASES	
Auto Club Insurance Association v. *Frederick & Herrud, Inc.*, 145 Mich. App. 722, 377 N.W.2d 902 (1985)	4
Detroit Automobile Inter-Insurance Exchange v. *Detroit Mutual Automobile Insurance Co.*, 337 Mich. 50, 59 N.W.2d 80 (1953)	5
Federal Kemper Insurance Co. v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986)	4
Kelly v. *Kelly*, 54 Mich. 30, 19 N.W. 580 (1984)	5
Metropolitan Life Insurance Co. v. *Massachusetts*, 471 U.S. 724, 739–740 (1985)	3
Metropolitan Life Insurance Co. v. *Taylor*, 481 U.S. ___, 95 L.Ed.2d 55, 107 S.Ct. ___ (1987)	3, 6
Pilot Life Insurance Co. v. *Dedeaux*, 481 U.S. ___, 95 L.Ed.2d 39, 107 S.Ct. 1549 1987	3, 6
STATUTES:	
Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144, Section 514, 29 U.S.C. § 1144(a), 29 U.S.C. § 1144(b)(2)(A), 29 U.S.C. § 1144(b)(2)(B)	*passim*
Labor Management Relations Act, 1947, 29 U.S.C. § 141, *et. seq.*	2
McCarran-Ferguson Act, 15 U.S.C. § 1011 *et. seq.* (1982)	3
Michigan No-Fault Automobile Insurance Act, M.C.L.A. § 500.3101 *et. seq.*	2, 4

No. 87-1598

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1987

NORTHERN GROUP SERVICES, INC., *et al.*,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., *et al.*,
Respondents.

BRIEF OF AMICUS CURIAE THORN APPLE VALLEY, INC. IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

INTEREST OF AMICUS CURIAE

Thorn Apple Valley, Inc. ("TAV"), employs approximately 2,500 employees in its meat processing and distributing operations in Michigan, North Carolina and approximately 10 other states. TAV sponsors in excess of 15 self-insured[1] and self-administered medical plans which cover virtually all of these employees. Most of TAV's plans, covering the majority of its employees, were the product of collective bargaining between TAV and labor organizations representing appropriate bargaining units of TAV's nonsupervisory employees. All of TAV's plans contain coordination of benefits clauses which, similar to petitioners' plans, provide that whenever a plan beneficiary is involved in an automobile accident and has automobile insurance coverage available "the auto insurance carrier will be primary."

TAV and its plans have been involved extensively in litigation with numerous Michigan automobile insurance car-

[1] TAV's medical plans carry aggregate stop loss coverage.

riers, including most of the respondents.[2] In this litigation, the claims which respondents threatened to bring against petitioners were actually pursued against TAV or its plans in the Michigan courts. Typically, in these cases, the auto carrier has paid medical benefits to or on behalf of a beneficiary of one of TAV's plans, the plan has declined to reimburse the carrier for the benefits and the carrier has then sued TAV (or the plan) in state court for reimbursement for those payments, claiming rights against the plan under the Michigan common law of subrogation. In the course of litigating these subrogation claims, the carriers have invoked the same state law policies purportedly emanating from Michigan's No-Fault Automobile Insurance Act, M.C.L.A. § 500.3101 *et. seq.*, that were considered by the Sixth Circuit below. TAV has urged that because the carriers' claims "relate to" an employee benefit plan the claims are themselves preempted by ERISA.

TAV's interest in the disposition of this petition derives not only from its involvement in state court litigation presenting questions regarding the scope of ERISA preemption which are identical to those decided by the Sixth Circuit, but also from the fact that the Sixth Circuit's decision fails to consider or address the nature of the claims which although only threatened against petitioners have in fact been brought and litigated in the Michigan courts against TAV. The state court litigation in which TAV has been involved represents the precise procedural context in which petitioners' ERISA preemption arguments would have been presented had petitioners not chosen to commence their action for declaratory and injunctive relief in the district court. TAV's interests are also vitally affected by this petition inasmuch as the Sixth Circuit's decision substantially subverts the administration of TAV's fringe benefit plans most of which, unlike petitioners' plans, were the product of collective bargaining under the Labor Management Relations Act. 29 U.S.C. § 141, *et.seq.*

[2] TAV is or has been involved in litigation of this type with State Farm Mutual Insurance Company, Auto Club Insurance Association, Farmers Insurance Exchange and Allstate Insurance Company.

ARGUMENT

Review is warranted in this case because the Sixth Circuit's decision directly conflicts with this Court's decision last term in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. ____, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). By failing to consider the nature of claims threatened by respondents, which prompted petitioners to commence this action in the district court in the first place, the Sixth Circuit unnecessarily reached and erroneously decided complex and abstract questions concerning the interpretation of ERISA's preemption, "insurance savings" and "deemer" clauses, provisions which this Court has previously observed are "not a model of legislative drafting." *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 739-740 (1985).

This Court succinctly ruled in *Pilot Life* that state common law tort and contract claims brought against ERISA plans, even insured ERISA plans, are preempted by ERISA. See also *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. ____, 95 L.Ed.2d 55, 107 S.Ct. ____ (1987). The Court reasoned that such lawsuits seeking to challenge the administration of ERISA plans "relate to" those plans within the meaning of ERISA's express preemption clause. 29 U.S.C. § 1144(a). The Court also rejected the contention that such state law claims were "saved" from preemption because they "regulate insurance" under ERISA's "insurance savings" provision. 29 U.S.C. § 1144(b)(2)(A). Applying definitional criteria fashioned under the McCarran-Ferguson Act, 15 U.S.C. §1011 *et. seq.*, for determining whether a practice constitutes the "business of insurance," the Court concluded that the Mississippi tort and contract claims which were there at issue and which had been asserted against an insured disability plan provided by a Mississippi employer had "roots-...firmly planted in the general principles of Mississippi tort and contract law." Thus, the Court held, these common law claims were not specifically directed at the insurance industry and were not saved from preemption by the "insurance

savings" clause. The Court reached this conclusion notwithstanding the fact that most contemporary applications of these Mississippi claims apparently had involved plaintiffs seeking "punitive damages from insurance companies for failure to pay a claim under an insurance contract." Having rejected arguments under the "insurance savings" provision, the Court declined to reach the more subtle implications of ERISA's "deemer" clause. 29 U.S.C. § 1144(b)(2)(B).

The same analysis used by the Court in *Pilot Life* could and should have been used by the Sixth Circuit here. Petitioners commenced this action in the district court because respondents had threatened to bring claims against them for restitution for benefits paid by respondents to beneficiaries under petitioners' plans. The threatened claims against petitioners are identical to the claims which have been actually brought by numerous insurance carriers, including most of the respondents, against TAV and its plans. These claims are predicated on the Michigan common law of subrogation. Having invoked the Michigan courts' jurisdiction to resolve these subrogation claims against TAV, the insurance carriers have then proceeded, successfully in some cases, to urge that policy emanations from Michigan's No-fault Automobile Insurance Act, M.C.L.A. 500.3101 *et. seq.*, require that the coordination of benefits provisions in their insurance policies prevail over the conflicting coordination of benefits provisions in TAV's ERISA plans. See, e.g., *Auto Club Insurance Association* v. *Frederick & Herrud, Inc.*, 145 Mich. App. 722, 377 N.W.2d 902 (1985).[1] In this regard, no case law holds that Michigan's no-fault insurance legislation independently creates a cause of action for restitution between an automobile insurance carrier and an employee benefit plan, whether insured or uninsured. The reported cases resolve only the question of priority between conflicting policy provisions where the issue of priority alone has been litigated. *Id.*; see also *Federal Kemper Insurance Co.* v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986).

[1] TAV was formerly known as Frederick & Herrud, Inc.

The common law subrogation claims on which the Michigan courts' adjudications of "priority" disputes between insurance carriers and health benefit plans are premised is not, however, a doctrine limited to the insurance industry or to "insurance law." Rather, as with the Mississippi tort and contract doctrines deemed preempted in *Pilot Life*, Michigan's subrogation doctrine was formulated in noninsurance cases. E.g., *Kelly* v. *Kelly*, 54 Mich. 30, 19 N.W. 580 (1884). Only years later has it been adapted to resolve priority disputes between insurance companies. See, e.g., *Detroit Automobile Inter-Insurance Exchange* v. *Detroit Mutual Automobile Insurance Co.*, 337 Mich. 50, 59 N.W. 2d 80 (1953).

Had the Sixth Circuit properly considered the nature of the common law subrogation claims threatened by respondents against petitioners before plunging into its exhaustive analyses of Michigan's no-fault litigation and ERISA's preemption provisions, it need never have reached the abstractions posed by the court in the first paragraph of its opinion. Thus, regardless of whether or not ERISA preempts Michigan's No-Fault Automobile Insurance Act, to the extent that Act allows automobile insurers in Michigan to issue policies which conflict with ERISA plans — as the issue was posited by the Sixth Circuit — the claims initially threatened by respondents against petitioners arise under the Michigan common law doctrine of subrogation, not under Michigan's insurance laws. These claims are for this reason preempted by ERISA. They plainly "relate to" petitioners' ERISA plans and do not arise under any "law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). Accordingly, in view of this Court's holding in *Pilot Life*, there was no need for the Sixth Circuit to address the applicability of the "deemer clause," or to engage in a comprehensive balancing the national interest in uniform administration of employee benefit plans against policies favoring state primacy in the regulation of insurance.

SUMMARY OF ARGUMENT

Review in this case is warranted because the Sixth Circuit erroneously and needlessly decided abstract questions of law after sidestepping the controversies which initially caused petitioners to invoke the district court's jurisdiction. The claims which respondents threatened to bring against petitioners arise under Michigan's common law of subrogation. They do not arise under Michigan's No-Fault Automobile Insurance Act or under other insurance laws. Policies emanating from Michigan's no-fault legislation have been invoked merely to support respondents' interpretation of how their subrogation claims should ultimately be decided. Nevertheless, the initial common law subrogation claims threatened by respondents against petitioners are no different than the common law tort and contract claims this Court held were preempted by ERISA in *Pilot Life Insurance Co.* v. *Dedeaux* and in *Metropolitan Life Insurance Co.* v. *Taylor*.

CONCLUSION

For the foregoing reasons, in addition to those urged by petitioner, the petition for writ of certiorari should be granted.

Respectfully submitted,

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

NORTHERN GROUP SERVICES, INC., et. al.,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, et. al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court grant certiorari on an ERISA pre-emption claim, where the state coordination of benefits law at issue is unique to Michigan, and where there is no conflict among the circuits as to whether a state's coordination of benefits rules are pre-empted by ERISA?

2. Should this Court review the Sixth Circuit's decision concerning the meaning of ERISA's deemer clause when the Michigan no-fault coordination of benefits law does not even relate to or regulate ERISA plans to such an extent as to come within the ERISA's initial pre-emption clause?

3. Should this Court decide academic issues concerning pre-emption where even if the state law for resolving coordination of benefits conflicts were pre-empted, a federal common law rule would have to be fashioned on the basis of state law, and the federal common law rule would subject the ERISA plans to the same alleged economic and administrative burdens as the state rule?

4. Should this Court grant certiorari where the pre-emption issues raised in the petition are irrelevant since the petitioners' plans expressly incorporated Michigan law?

STATEMENT OF CORPORATE AFFILIATES, PARENTS, AND NOT-WHOLLY-OWNED SUBSIDIARIES

ALLSTATE INSURANCE COMPANY

Parent: Sears, Roebuck and Company

Affiliates and Subsidiaries: Allstate Insurance Company of Canada; Allstate Life Insurance Company of Canada; Armtek Corporation; Sears Canada, Inc.; Sears Acceptance Company Inc.

AUTO OWNERS MUTUAL INSURANCE COMPANY

None

CITIZENS INSURANCE COMPANY OF AMERICA

Parent: The Hanover Insurance Company

Affiliates: Massachusetts Bay Insurance Company; Beacon Insurance Company of America; California Compensation and Fire Company

Subsidiary: AMGRO, Inc.

MICHIGAN MUTUAL INSURANCE COMPANY

None

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Subsidiary: State Farm County Mutual Insurance Company of Texas

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
STATEMENT OF CORPORATE AFFILIATES, PARENTS, AND NOT-WHOLLY-OWNED SUBSIDIARIES	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	iv
SUMMARY OF ARGUMENT	1
ARGUMENT	3
A. THERE IS NO CONFLICT– AMONG THE CIRCUITS	3
B. PETITIONERS MISCHARACTERIZE THE SIXTH CIRCUIT DECISION; THE DECISION WAS NARROW AND CLOSELY TIED TO THE PARTICULAR SITUATION PRESENTED IN THIS CASE	5
C. MICHIGAN'S RULE FOR RESOLVING COORDINATION OF BENEFITS CONTESTS WHEN NO-FAULT IS INVOLVED IS UNIQUE; REVERSING THE SIXTH CIRCUIT'S DECISION WOULD HAVE LITTLE IMPACT SINCE EVEN IF STATE LAW WERE PRE-EMPTED THE CONSEQUENCES FOR ERISA PLANS WOULD BE THE SAME	7
D. THE PETITIONERS' PLANS SPECIFICALLY PROVIDE THAT MICHIGAN LAW IS CONTROLLING	9
E. THE MICHIGAN LAW DOES NOT COME WITHIN THE THRESHOLD SCOPE OF ERISA PRE-EMPTION	12
F. THE HIGHLAND PLAN IS CLEARLY INSURED	14
CONCLUSION AND RELIEF	15

TABLE OF AUTHORITIES

Cases	Page
Alessi v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504; 101 S.Ct. 1895; 68 L.Ed.2d 402 (1981)	2
Blue Cross & Blue Shield of Kansas, Inc. v. *Riverside Hosp.*, 237 Kan. 829; 703 P.2d 1384 (1985)	8
Children's Hosp. v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985)	10
Employers Ass'n of New Jersey v. *New Jersey*, 601 F.Supp. 232 (D. N.J. 1985); *aff'd mem.*, 774 F.2d 1151 (3rd Cir. 1985)	3, 13
Federal Kemper Ins. Co., Inc. v. *Health Insurance Admin., Inc.*, 424 Mich. 537; 383 N.W.2d 590 (1986)	1, 8
Firestone Tire & Rubber Co. v. *Neusser*, 810 F.2d 550 (6th Cir. 1987)	13
Fort Halifax Packing Co. v. *Coyne*, 482 U.S. ___; 107 S.Ct. 2211; 96 L.Ed.2d 1 (1987)	2, 13
Holliday v. *Xerox Corp.*, 555 F.Supp. 51 (E.D. Mich. 1982); *aff'd*, 732 F.2d 548 (1984); *cert. denied*, 469 U.S. 917 (1984)	9
Lane v. *Goren*, 743 F.2d 1337 (1984); *cert. denied*, 474 U.S. 888 (1985)	12
Martori Bros. Distributors v. *James-Massengale*, 781 F.2d 1349 (9th Cir. 1986); *cert. denied*, 107 S.Ct. 435 (1986)	12
Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724; 105 S.Ct. 2380; 85 L.Ed.2d 728 (1985)	2, 4, 5, 7, 14
Michigan United Food & Commercial Workers Union v. *Baerwaldt*, 767 F.2d 308 (6th Cir. 1985); *cert. denied*, 474 U.S. 1059 (1986)	14
Northeast Dept. ILGWU Health & Welfare Fund v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3rd Cir. 1985)	7, 8

TABLE OF AUTHORITIES — (Continued)

Cases Page

Northern Group Services, Inc. v. *Auto Owners Ins. Co.*, 833 F.2d 85 (1987) 4, 6, 8, 14

Physicians Health Plan, Inc. v. *Citizens Ins. Co.*, 673 F.Supp. 903 (W.D. Mich. 1987) 13

Pilot Life Ins. Co. v. *Dedeaux*, ___U.S. ___; 107 S.Ct. 1549; 95 L.Ed.2d 39 (1987) 2

Rebaldo v. *Cuomo*, 749 F.2d 133 (2d Cir. 1984); *cert. denied*, 472 U.S. 1008 (1985) 12

Shaw v. *Delta Airlines, Inc.*, 463 U.S. 85; 103 S.Ct. 2890; 77 L.Ed.2d 490 (1983) 2, 12

Sommers Drug Stores Profit Sharing Trust v. *Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986); *cert. denied*, 107 S.Ct. 884 and 1298 (1987) 13

Statutes

29 U.S.C. §1104(1)(D) 10

29 U.S.C. §1144 ..... 2, 12

Michigan No-Fault Insurance Act, Mich. Comp. Law §500.3109a; Mich. Stat. Ann. §24.13109(1) 1, 8, 13

Secondary Authorities

8A Appleman, *Insurance Law & Practice* §4906-09 8

Sherrick, *ERISA Preemption: An Introduction*, 64 Mich. Bar Journal 1074 (Oct. 1985) 8, 9

Restatement (Second) of Conflicts §187 10

SUMMARY OF ARGUMENT

For several reasons, the Court should not accept this case for review.

First, the Sixth Circuit was correct in ruling that Michigan's law for resolving conflicts between coordination of benefits clauses should apply to ERISA plans. Nothing in ERISA conflicts with the Michigan law or its goals of reducing the cost of compulsory auto insurance and containing health care costs.

Second, there is no conflict among the circuits — no court has held that state rules for resolving coordination of benefits conflicts are pre-empted by ERISA. Nor does the case have any impact beyond Michigan. The Michigan no-fault coordination of benefits law is unique, and the Sixth Circuit carefully circumscribed its decision based on the particular circumstances of this case. It would make very little difference if this Court decided the case. Even if the state rule is pre-empted, the courts will have to fashion a federal common law rule of accommodation when there are intractable conflicts between coordination of benefits clauses. Any federal rule will borrow heavily from established state law which, at the very least (without even considering §3109a of the Michigan No-Fault Act and *Federal Kemper*), would require benefit plans to share primary liability. ERISA plans will still have to pay more than their coordination provisions say they will pay. So the pre-emption issue is much ado about nothing.

Third, while the petition contends that the deemer clause issue is deserving of this Court's review, there are at least two alternative grounds for affirmance. First, the same result could be reached because the Michigan law at issue does not come within the scope of ERISA pre-emption as a threshold matter — it does not purport to regulate ERISA plans and it only affects them tangentially. Second, the plans contain express contract provisions agreeing to be governed by Michigan law, an issue which the Sixth Circuit did not consider because it was not necessary to its disposition of the case. Petitioners now claim that applying Michigan law would cause all sorts of problems for them, but the

petitioners' plans expressly provide that they are to be interpreted by Michigan law.

In the last few years this Court has repeatedly had to revisit 29 U.S.C. §1144 to decide questions of ERISA pre-emption.[1] This Court should not be asked to review every state law which in some way touches an ERISA plan and iron out every conceivable wrinkle involving pre-emption. The case at bar is particularly inappropriate for Supreme Court review.

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[1]*Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. _____; 107 S.Ct. 2211; 96 L.Ed.2d 1 (1987); *Pilot Life Ins. Co.* v. *Dedeaux*, _____ U.S. _____; 107 S.Ct. 1549; 95 L.Ed.2d 39 (1987); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724; 105 S.Ct. 2380; 85 L.Ed.2d 728 (1985); *Shaw* v. *Delta Airlines, Inc.*, 466 U.S. 85; 103 S.Ct. 2890; 77 L.Ed.2d 490 (1983); *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504; 101 S.Ct. 1895; 68 L.Ed.2d 402 (1981).

ARGUMENT

A. THERE IS NO CONFLICT AMONG THE CIRCUITS

Petitioners suggest that review is warranted because the Sixth Circuit decision is inconsistent with pre-emption decisions of other circuits. Petition pp. 7, 13. However, *none* of the cases cited involved coordination of benefits provisions or state rules to resolve contests when there is duplicate coverage. *There simply is no conflict among the circuits about how to treat coordination of benefits under ERISA.* Indeed, the only other circuit to consider the issue ruled that a state rule for resolving coordination of benefits conflicts was *not* pre-empted. *Employers Ass'n of New Jersey* v. *New Jersey*, 601 F.Supp. 232 (D. N.J. 1985), *aff'd mem.*,774 F.2d 1151 (3rd Cir. 1985).

In the absence of any direct conflict among the circuits in cases involving a similar issue, petitioners rely on an apparent inconsistency in the theory enunciated by some other courts. While some decisions from other circuits have employed an interpretation of the deemer clause focussing simply on whether the plan is insured or not, none of the cited cases considered the question the Sixth Circuit addressed: whether there might be exceptions or qualifications to the deemer clause, and whether uninsured plans are immune from *all* state insurance laws. The other courts were not faced with a compelling situation like the one in this case involving powerful state interests testing the limits of the deemer clause. In other words, although the analysis used by the Sixth Circuit may have differed from the theory expressed in the cited cases, the results in these cases can be harmonized. Applying the Sixth Circuit balancing test to the fact situations in the cited cases, the Sixth Circuit might very well arrive at the same result — the laws would be pre-empted. And if the other circuits were faced with the case at bar, they might very well reach the same result and conclude that the deemer clause in some circumstances allows application of insurance rules to uninsured plans.

Petitioners casually suggest that the Sixth Circuit "directly repudiated this Courts' [sic] numerous decisions that any state law mandating benefits should be pre-empted." Petition p. 9. The Sixth Circuit of course did not "directly repudiate" any decision of this Court. Moreover, this case does not involve a mandated-benefit law. Finally, this Court unanimously held in *Metropolitan Life* that mandated benefit laws were *not* pre-empted where they were insurance regulations within ERISA's savings clause.

Petitioners do not seriously contend that the Sixth Circuit decision conflicts with any decision of this Court. Quite correctly, the Petition does not argue that the Sixth Circuit decision conflicts with *Metropolitan Life*. There the Court held that when a state insurance law is at issue, "[t]he presumption is against pre-emption." 471 U.S. at 741. As the Sixth Circuit noted, this Court did not render a definitive interpretation of the deemer clause in *Metropolitan Life*. *Northern Group Services, Inc.* v. *Auto Owners Ins. Co.*, 833 F.2d 85, 90-91 (1987). Because *Metropolitan Life* did not reach or involve any issue concerning the deemer clause, the Court's comment about what the deemer clause might mean was *obiter dicta*. Moreover, as the Sixth Circuit noted:

> Nor is this approach necessarily inconsistent with the dicta in *Metropolitan Life* concerning insured versus self-insuring plans. 471 U.S. at 740-41, 747, 105 S.Ct. at 2389-90, 2393. We preserve a distinction between insured and self-insuring plans. Insured plans would be *per se* "open to indirect regulation." *Id.* at 747, 105 S.Ct. at 2393. Self-insuring plans would be subject to state regulation only when no independent federal interest in national uniformity exists to inform and guide the creation of federal common law.
>
> *Id.* at 94-95 (citations omitted).

B. PETITIONERS MISCHARACTERIZE THE SIXTH CIRCUIT DECISION; THE DECISION WAS NARROW AND CLOSELY TIED TO THE PARTICULAR SITUATION PRESENTED IN THIS CASE

To grab this Court's attention, the petition misrepresents the Sixth Circuit's holding and exaggerates its implications. The Sixth Circuit's exceptionally thorough, well-reasoned opinion is the best refutation of the petitioners' claims.[2]

Apparently concluding that only by enormous overstatement could they make it appear that this case is significant enough for this Court to hear, petitioners assert that "the Sixth Circuit virtually destroyed the effect of ERISA pre-emption and permits [sic] virtually complete state regulation of all ERISA plans." Petition p. 11. The Sixth Circuit opinion does not in any way touch upon the general pre-emption of most state laws or allow "virtually complete" state regulation of ERISA plans — it only applies to state *insurance* laws, and even then narrowly holds that only *some* insurance laws can be applied to uninsured plans.

Petitioners allege that the Sixth Circuit opinion runs counter to the central purpose of pre-emption: national uniformity of plan regulation. But Congress enacted the savings clause which expressly sanctifies and preserves state insurance laws, despite the prospect of differing insurance regulations from state to state affecting ERISA plans. As this Court recognized in *Metropolitan Life:*

> Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.
>
> 471 U.S. at 747.

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[2]In response to the decision, petitioners moved for rehearing and rehearing en banc, raising the same arguments they now assert in their certiorari petition. The panel which issued the opinion rejected these arguments and denied the petition for rehearing. Notably, not a single Sixth Circuit judge requested a vote on the petition for en banc rehearing. Order Dec. 30, 1987.

Congress expressly determined that preserving state insurance laws (even insofar as they affect ERISA plans) is *more important* than the interest in national uniformity.

Petitioners also assert that the Sixth Circuit decision has the effect of "voiding" the deemer clause. Petition p. 12. Of course, the Sixth Circuit emphasized the narrowness of its holding; only to a "limited degree" would self-insured plans be affected by certain state insurance laws. 833 F.2d at 95. Using the Sixth Circuit's balancing approach, the deemer clause would still immunize self-insured plans from most insurance laws, *i.e.* where the state's purpose is to regulate the content of ERISA plan benefits, or where there is some federal policy or interest to inform and guide the creation of federal common law, or where application of a federal rule would not substantially disrupt a complex regulatory scheme of benefits coverage. *Id.* at 93, 95. The Sixth Circuit did not purport to announce any categorical rule applicable to other settings. The impact of its holding is quite limited.

The Sixth Circuit decision was closely wedded to the particular features of the Michigan law at issue and the special policies behind it. The court emphasized the particular circumstances of the matrix of overlapping insurance programs and the need for a uniform rule to apportion liability, plus the unique aspect of compulsory no-fault insurance. *Id.* at 93-94. What distinguishes this from other pre-emption cases is that exempting uninsured plans would substantially disrupt the state's uniform scheme of no-fault coordination of benefits law, while there is no discernible federal interest with regard to coordination of benefits. Id. at 94.

C. MICHIGAN'S RULE FOR RESOLVING COORDINATION OF BENEFITS CONTESTS WHEN NO-FAULT IS INVOLVED IS UNIQUE; REVERSING THE SIXTH CIRCUIT'S DECISION WOULD HAVE LITTLE IMPACT SINCE EVEN IF STATE LAW WERE PREEMPTED THE CONSEQUENCES FOR ERISA PLANS WOULD BE THE SAME

Under the singular Michigan law at issue here, when there is a conflict between competing coordination of benefits provisions in a Michigan no-fault policy and other applicable benefit coverage, for reasons of public policy the no-fault provision must be given effect and no-fault only has to provide benefits if and when the other coverage is exhausted. Because the Michigan no-fault statute is virtually unique, the implications of the Sixth Circuit's ruling do not extend beyond Michigan. It leaves things exactly the same for plans in other states which do not have such a law. Even for the petitioners the consequences are essentially the same regardless of whether the Michigan rule on coordination of no-fault benefits is pre-empted.

If the Michigan rule for resolving coordination contests between no-fault and other coverage is pre-empted, some other rule must be found to take its place, since the no-fault policies and the ERISA plans have incompatible provisions each denying primary liability because of the other coverage. (Based solely on the documents defining the coverage obligations, absent some external principle for allocating liability, a claimant would end up with two secondary coverages and no primary coverage.) So, if state law is pre-empted, the courts must devise a federal rule to reconcile the conflict.

The federal statute does not supply a rule. ERISA "does not regulate the substantive content of welfare benefit plans," *Metropolitan Life*, 471 U.S. at 732, and there is nothing in the legislative history about coordination provisions or rules to resolve conflicts when there is duplicate coverage. So the courts would have to develop a federal common law rule. *Northeast Dept. ILGWU Health & Welfare Fund* v. *Teamsters Local Union No.*

229 Welfare Fund, 764 F.2d 147, 158 (3rd Cir. 1985) (fashioning federal common law rules with regard to conflicting coordination of benefits clauses in ERISA plans). Given the absence of any federal policy in this area, the courts would inevitably adopt a federal rule based on general state law. *Northeast Dept. ILGWU,* 764 F.2d at 159-162; *Northern Group,* 833 F.2d at 94. Under general insurance law (without considering §3109a and *Federal Kemper*), when there are mutually repugnant coordination clauses, the courts invariably apportion primary liability on a pro-rata basis. *See* 8A Appleman, *Insurance Law & Practice* §4906-09; *Federal Kemper Ins. Co., Inc.* v. *Health Insurance Admin., Inc.,* 424 Mich. 537, 542-543; 383 N.W.2d 590 (1986); *Northeast Dept. ILGWU,* 764 F.2d at 161 n. 13; *Blue Cross & Blue Shield of Kansas, Inc.* v. *Riverside Hosp.,* 237 Kan. 829; 703 P.2d 1384 (1985).

In short, resolution of the pre-emption issue would not make any substantial difference. Taking this case would be a fruitless academic exercise, since even if the Court ultimately found the Michigan no-fault coordination rule pre-empted, the federal common law rule would inevitably be patterned after the general state rule. Since the majority common law rule (without considering §3109a and *Federal Kemper*) would at the very least require ERISA plans to pay a pro-rata portion of the benefits, *even if there is pre-emption,* ERISA plans will have to share primary liability.

The Petition assumes that if the state rule is pre-empted, then the conflict of coordination clauses must necessarily be resolved in favor of the ERISA plans: the coordination clauses in the no-fault policies must be disregarded and no-fault will be primarily liable. However:

> It must be kept in mind that preemption is *not* fatal in these cases. Preemption simply means that federal, rather than state law governs the conduct at issue.

> Sherrick, *ERISA Preemption: An Introduction*, 64 Michigan Bar Journal 1074, 1081 (October 1985) (emphasis in original).

See also, Holliday v. *Xerox Corp.*, 555 F.Supp. 51, 55 (E.D. Mich. 1982); *aff'd*, 732 F.2d 548 (1984); *cert. denied*, 469 U.S. 917 (1984) ("if the state law is preempted, then the contract must be construed in accordance with federal law, in this case the federal common law of contract . . . Preemption would not make the contract a nullity"). There is nothing in ERISA to suggest that Congress intended to invalidate any insurance policy provisions or to require that no-fault insurers provide primary benefits contrary to the terms of their policies. *Especially in view of the insurance savings clause, ERISA clearly does not permit provisions of insurance policies to be cavalierly disregarded or nullified.*

D. THE PETITIONERS' PLANS SPECIFICALLY PROVIDE THAT MICHIGAN LAW IS CONTROLLING

Even if the state rule were pre-empted, and even if the deemer clause absolutely insulated uninsured plans from every state insurance law (no matter how powerful the policies favoring application of that law), the plans are still bound by their contract provisions which expressly incorporate Michigan law.

Because the result in this case is fully justified on this alternative ground, it is unnecessary to reach the issues trumpeted in the petition as warranting review. Even if the Court were inclined to consider the deemer clause issue in a proper case, here that issue is purely academic.

All of the plans involved in this case have provisions expressly agreeing to be bound by Michigan law:

> The Plans shall be interpreted under the laws of Michigan.
>
> R. 56 Ex. 5 (Jt. App. 311) (Highland Plan).
>
> Any provision of the Plan which is in conflict with any applicable law or regulation of the State in which the Plan is

> delivered shall be considered amended so as to conform to the requirements of such law or regulation.
>
> Alcott Dep. Ex. 8 (Jt. App. 717) (Masco Plan).
>
> To the extent not inconsistent with Federal law the Plan shall be interpreted under the laws of Michigan.
>
> R. 52 Ex. C (Jt. App. 250) (Masco Plan).[3]

By their own choice, the petitioners' coordination of benefits clauses *must be construed and enforced according to Michigan law.* It is axiomatic that ERISA plans, and their administrators and fiduciaries, are bound by the terms of the plan documents, 29 U.S.C. §1104(1)(D). Very simply, *the plan is a binding contract with the participants, so the petitioners are not at liberty to abandon or ignore the choice-of-law clause at their whim.*

Petitioners argue that ERISA's pre-emption clause entitles them to disregard their own choice-of-law provisions. But ERISA's pre-emption clause does not change the rule that a choice-of-law provision is binding. Restatement (Second) of Conflicts §187. If state law is pre-empted, it is replaced by federal common law. Federal common law would apply the universal rule that a choice-of-law provision must be enforced.

Previously, petitioners cited a footnote in *Children's Hosp.* v. *Whitcomb,* 778 F.2d 239, 242 n. 1 (5th Cir. 1985), to try to escape their voluntary choice-of-law provisions. There, the court cursorily dismissed the contention that a choice-of-law provision meant that state law was not pre-empted. However, the argument here is not that pre-emption is waived or that pre-emption does not apply, but rather than *even if* ERISA pre-empts the Michigan

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[3]There has never been any factual development in this case which might shed light on the exact meaning of these provisions — each of which is worded slightly differently, but each of which clearly incorporates Michigan law to some degree. There is no testimony about the intent of the drafters, or the reasonable understanding of the plan participants. Nor did either the district court or court of appeals make any findings or interpretation of the provisions. (The Sixth Circuit never addressed the choice-of-law issue at all.) This is yet another reason why this case is not appropriate for Supreme Court review.

coordination rule, the plan documents must be enforced under federal law. Federal common law, applying general rules of contract interpretation, will enforce the provisions in the petitioners' plans stipulating that they are to be interpreted according to Michigan law.

Giving effect to a choice-of-law provision in an ERISA plan does not violate pre-emption. *Pre-emption only means that state rules cannot be imposed on plans* from the outside, that a state cannot force a plan to follow state law. The plans in this case *chose* to incorporate state law. The state is not imposing any requirements on ERISA plans, so pre-emption is given full force and effect. There is no state interference with an ERISA plan, because the plans dictated their own terms and voluntarily incorporated state law.

This is not a general waiver of ERISA pre-emption. The plans have not stipulated that state laws will apply instead of federal law; they have stipulated that the *Michigan* law applies. The plans did not consent to be governed by inconsistent laws of the several states; they deliberately chose to be interpreted according to the law of a single state to make plan administration simple and certain. The petitioners' choice-of-law provisions provide a single clear standard of reference for interpreting their plans' terms.

There is simply no federal policy or interest in disregarding the voluntarily-chosen provisions of an ERISA plan. Federal law is silent as to what provisions a plan should have, and leaves the parties free to work out their own terms. Far from prohibiting plans from choosing state law, the policies behind ERISA pre-emption *support* such choice-of-law provisions, according to petitioners' own explanation of the purposes of pre-emption. The plans are not subject to a multiplicity of inconsistent state regulations, because the petitioner plans chose to be bound by the law of a single state; so there is complete uniformity of regulation. Indeed, Michigan law affords a more definite and predictable legal context for the operation of the plans than the as yet undefined rules which may be devised under the federal common

law of ERISA. Petitioners further suggest that one of the foremost federal policies underlying ERISA is that the parties to a plan must be allowed to determine and define the terms of the plan. Petition pp. 9, 18. *That is precisely why their decision to abide by Michigan law must be respected.*

In short, petitioners cannot disavow their choice-of-law provisions on the pretext that these provisions negate federal pre-emption. Even if state law is pre-empted, federal common law would come into play, and federal common law will give effect to the plans' deliberate choice to be interpreted under Michigan law.

E. THE MICHIGAN LAW DOES NOT COME WITHIN THE THRESHOLD SCOPE OF ERISA PRE-EMPTION

Although the Sixth Circuit decided the case on the basis of the savings clause exception, the result is fully supportible on the alternative ground that the Michigan coordination of benefits law does not come within the scope of ERISA pre-emption in the first place.

It is firmly established that not all state laws with an impact on ERISA plans are pre-empted. ERISA does not pre-empt all state laws that "relate to" employee benefit plans, 29 U.S.C. §1144(a). It only pre-empts state laws that relate to employee benefit plans in a way that is more than "tenuous, remote, or peripheral," *Shaw*, 463 U.S. at 100 n. 21. Moreover, state laws are only pre-empted if they "purport to regulate, directly or indirectly, the terms and conditions of employee benefit plans," 29 U.S.C. §1144(c)(2). *See, Rebaldo* v. *Cuomo,* 749 F.2d 133, 137-139 (2d Cir. 1984); *cert. denied,* 472 U.S. 1008 (1985); *Lane* v. *Goren,* 743 F.2d 1337, 1339 (1984); *cert. denied,* 474 U.S. 888 (1985); *Martori Bros. Distributors* v. *James-Massengale,* 781 F.2d 1349, 1356-1359 (9th Cir. 1986); *cert. denied,* 107 S.Ct. 435 (1986).

Michigan's no-fault coordination of benefits rule does not purport to regulate ERISA plans and it only tangentially affects them. As the court concluded when faced with this precise issue

in *Physicians Health Plan, Inc.* v. *Citizens Ins. Co.*, 673 F.Supp. 903, 906-907 (W.D. Mich. 1987), "the Court finds 3109a is not sufficiently related to plaintiff's employee benefit plan to trigger ERISA pre-emption." Also, in *Employers Ass'n of New Jersey* v. *New Jersey*, 601 F.Supp. 232, 239-240 (D. N.J. 1985), *aff'd mem.*, 774 F.2d 1151 (3rd Cir. 1985), the court held that a strikingly similar New Jersey law was not pre-empted by ERISA. The court noted that, "[n]othing in the New Jersey statute challenged herein mandates that employers provide health benefits for their employees . . . The challenged portions of the New Jersey law are not directed at employee benefit plans or trust funds."

The Michigan no-fault coordination of benefits law is not aimed at ERISA plans, nor does it deal with any subject regulated by ERISA.[4] The Michigan law at issue is concerned with no-fault automobile insurance, not employee benefit plans. It does *not* require employee benefit plans to provide coverage for automobile accidents or even to provide health benefit coverage at all. Its effect on coordination clauses in health plans is purely incidental. In addition, the law affects the plans' relations with third parties (no-fault insurers); it does not affect the plans' relationships with their participants, fiduciaries or sponsoring employers. *See, Sommers Drug Stores Profit Sharing Trust* v. *Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986); *cert. denied*, 107 S.Ct. 884 and 1298 (1987); *Firestone Tire & Rubber Co.* v. *Neusser*, 810 F.2d 550 (6th Cir. 1987).

In short, §3109a does not materially "relate to" or "purport to regulate" ERISA plans, and so it is not pre-empted.

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[4]As this Court recently observed of ERISA pre-emption,

> If a State creates no prospect of conflict with a federal statute, there is no warrant for disabling it from attempting to address uniquely local social and economic problems.
>
> *Fort Halifax Packing Co., Inc.* v. *Coyne*, 482 U.S. ___; 107 S.Ct. 2211; 96 L.Ed.2d 1, 16 (1987).

F. THE HIGHLAND PLAN IS CLEARLY INSURED

As shown in this brief, regardless of whether the petitioners' plans are insured, there are several reasons why they must be interpreted according to Michigan coordination of benefits law. The Sixth Circuit additionally decided that the Highland Plan *is* insured, so it remains subject to Michigan insurance law under the savings clause. Petitioners suggest that this marginal, subsidiary issue warrants review because the Sixth Circuit's conclusion is at odds with the Ninth Circuit.

The Sixth Circuit previously held that an ERISA plan with stop-loss insurance is an insured plan and subject to state insurance laws under *Metropolitan Life. Michigan United Food & Commercial Workers Union* v. *Baerwaldt*, 767 F.2d 308 (6th Cir. 1985); *cert. denied*, 474 U.S. 1059 (1986). *This Court declined to review the decision in Baerwaldt.* The Sixth Circuit here followed *Baerwaldt* because the Highland Plan has stop-loss insurance similar to that in *Baerwaldt*. The two Ninth Circuit cases cited by petitioners did not even cite or mention *Baerwaldt*. Moreover, the Ninth Circuit cases involved *only aggregate insurance*, not the *individual* insurance at issue in *Baerwaldt* and in the present case. Here, the insurance pays specific benefits for specific beneficiaries when the stated individual deductible is reached.

Petitioners argue that the Highland Plan is not insured because the Plan's sponsor, Highland Appliance Company, rather than the Highland Plan itself, technically purchased the insurance. This Court has already flatly rejected petitioners' approach. In *Metropolitan Life*, the Court expressly noted that most of the insurance contracts relating to the plans at issue "technically were issued to employers." 471 U.S. at 738 n. 15. Nevertheless, those insurance plans were held subject to state insurance law. Moreover, the District Court in the case at bar found as a matter of fact that Highland's insurance was "acquired by the Highland plan." R. 69 (Jt. App. 22). As the Sixth Circuit correctly noted in the case at bar, the petitioners' shell games to separate Highland Appliance Company from the Highland Plan are without merit because "[w]hether the actual insured is the employer or the ERISA plan, the stop-loss insurance is purchased to 'provide benefits for plans subject to ERISA.'" 833 F.2d at 91, quoting *Metropolitan Life*, 471 U.S. at 738 n. 15.

CONCLUSION AND RELIEF

The petition should be denied because this case is not appropriate for Supreme Court review. There is plainly no conflict among the circuits as to whether ERISA pre-empts state coordination of benefits rules from being applied to uninsured plans. Further, a decision on this issue would have no practical significance, since ERISA plans would be subject to similar rules even under federal law. Finally, the deemer clause issue (the issue which is the basis of the petition for certiorari) would never even be reached in this case, since there are several alternative grounds which fully justify the result below.

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